MANIPALCIGNA LIFETIME HEALTH INDIA PLAN

Policy Contract

B PREAMBLE

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

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

C DEFINITIONS

C.I STANDARD DEFINITIONS

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

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

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

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

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

- **Day Care Centre** Day Care Centre - A day care centre means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-
  - a. has qualified nursing staff under its employment
  - b. has qualified Medical Practitioner (s) in charge
  - c. has a fully equipped operation theatre of its own where surgical procedures are carried out
  - d. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

- **Day Care Treatment** Day Care Treatment refers to medical treatment, and/ or surgical procedure which is:
  - i) Undertaken under General or Local Anaesthesia in a hospital/day are centre in less than 24 hrs because of technological adv ancement, and
  - ii) Which would have otherwise required a hospitalization of more than 24 hours.

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

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

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

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

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

- **Grace Period** Grace Period means the specified period of time immediately following the premium due date during which 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  c. Must have been prescribed by a Medical Practitioner.

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

- **Migration** Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

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

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

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

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

- **Portability** Portability means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

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

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

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

- **Pre-existing Disease** Pre-existing Disease means any condition, ailment or injury or disease:

  a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or

  b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

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

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

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

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

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

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

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

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

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

C.II SPECIFIC DEFINITIONS

- **Age** Age or Aged means the completed age as on the last birthday.
- **Ambulance** Ambulance means a vehicle/ carrier operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
- **Annexure** Annexure means a document attached and marked as Annexure to this Policy.
- **Area of Cover** Area of Cover means the geographic coverage area as defined under the Policy and as particularly specified for the Insured Person in the Policy Schedule.
- **Associated Medical Expenses** Associated Medical Expenses shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anesthetist/ Specialist, excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalization in ICU.

  Associated Medical Expenses shall be applicable for covered expenses, incurred in Hospitals which follow differential billing based on the room category.
- **Company / Insurer** Company / Insurer mean ManipalCigna Health Insurance Company Limited.
- **Cosmetic Surgery** Cosmetic Surgery means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
- **Covered Relationships** Covered Relationships shall include spouse (same or opposite gender legally wedded), children, sibling of the Policyholder who are children of same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, Uncle, Aunt, Niece and, Nephew.
- **Eligibility** Eligibility means the provisions of the Policy that state the requirements to be complied with.
- **Emergency** Emergency shall mean a serious medical condition or symptom resulting from injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a medical practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the insured person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
- **Family Floater** Family Floater means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Inception Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period.
- **Inception Date** Inception Date means the Inception date of this Policy as specified in the Schedule.
- **Indian Resident** An individual will be considered to be resident of India, if he is in India for a period or periods amounting in all to one hundred and eighty-two days or more, in the immediate preceding 365 days.
- **In-patient** In-patient means an Insured Person who is admitted to hospital and stays for at least 24 consecutive hours for the sole purpose of receiving treatment.
- **Insured Person** Insured Person means the person (s) named in the Schedule to this Policy, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.
- **IRDAI** IRDAI means the Insurance Regulatory and Development Authority of India.
- **Outpatient** Outpatient means a patient who undergoes OPD treatment.
- **Policy** Policy means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy Contract and shall be read together.
- **Policy Anniversary** Policy Anniversary is the same date each year during the Policy Term as the Date of Commencement of Policy. If the date of Commencement of Policy is on 29th February, the Policy Anniversary will be taken as the last date of February.
- **Policy Period** Policy Period means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.
- **Policy Schedule** Policy Schedule means 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.
- **Policy Year** Policy Year means a period of 12 consecutive months within the Policy Period commencing from the Policy Anniversary Date.
- **Schedule** Schedule means schedule issued by Us, attached to and forming part of this Policy mentioning the details of the Policy Holder, Insured Persons, Sum Insured, Policy Period, Premium Paid(including taxes).
- **Sum Insured** Sum Insured means, subject to terms, conditions and exclusions of this Policy, the amount representing Our maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of that Insured Person.
  i. In case where the Policy Period for 2/3 years, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits up to the full Sum Insured as opted will be available for the second/ third year, unless specified otherwise.
  ii. In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.
- **Therapy** Therapy is the treatment of disease or disorders, as by some remedial, rehabilitating, or curative process with mental or physical illness without the use of drugs or operations.
- **TPA Third Party Administrator (TPA)** TPA Third Party Administrator (TPA) means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under TPA Regulations.
- **Waiting period** Waiting period means a time bound exclusion period related to condition (s) specified in the Policy Schedule or Policy which shall be served before a claim related to such condition (s) becomes admissible.

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

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

D BENEFITS COVERED UNDER THE POLICY

D.I LIMIT AND SCOPE OF COVER

D.I.1 Sum Insured:

Sum Insured[1] - Sum Insured[1] is coverage available under benefits from D.II.1 to D.II.15.

D.I.2 Deductible

If Deductible is opted under the Policy it will be applicable subject to below conditions:

1. The opted Deductible shall be applicable for each Policy Year.
2. The Deductible shall be applicable on the aggregate of all indemnity claims admissible under the Policy, in that Policy Year.
3. The Deductible shall apply on all indemnity covers. It shall not apply to Section D.II.9 Adult Health Check-up, Section D.II.15 Premium Waiver Benefit, optional packages i.e. Health+, Women+ and Critical Illness Add- On Rider, if opted.
4. The Company shall be liable to make payment under the Policy for any indemnity claim only when the Deductible is exhausted.

For the purpose of calculating the deductible and assessment of admissibility, all claims must be submitted in accordance with Section G.I.12 of the Claim Process.

All Policy terms, conditions, waiting periods and exclusions shall apply.

D.I.3 Major Illness:

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

1. Cancer Treatment

We will be covering Primary Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

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

Any tumour in the presence of HIV infection is excluded under this cover.

2. Coronary Artery By-Pass Surgery

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

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

3. Heart Valve Replacement

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

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

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

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

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

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

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

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

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

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

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

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

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic Encephalopathy.

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

Liver failure secondary to drug or alcohol abuse is excluded.

7. Heart Transplant

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

8. Cardiac arrest (excluding angioplasty)

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

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

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

9. Bone Marrow Transplant

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

The following are excluded:

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

10. Neurosurgery

We will be covering any:

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

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

11. Surgical Treatment for Benign Brain Tumour

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

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

ii. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour.

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

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

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

b. Undergone surgical resection or radiation therapy to treat the brain tumour.

The following conditions are excluded:

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

12. Pulmonary artery graft surgery

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

13. Aorta Graft Surgery

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

For the above definition, the following are not covered:

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

14. Stroke Treatment

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

We will be covering surgical treatment of Stroke limited to:

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

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

The following are excluded:

a. Transient ischemic attacks (TIA);

b. Traumatic injury of the brain;

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

15. Surgical treatment of Coma

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

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

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

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

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

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

The following are excluded:

Coma resulting directly from alcohol or drug abuse is excluded.

16. Skin Grafting Surgery for Major Burns

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

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

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

17. Surgery for Pheochromocytoma

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

18. Permanent Paralysis of Limbs

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

19. Motor Neuron Disease with Permanent Symptoms

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

20. Multiple Sclerosis with Persisting Symptoms

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

21. Fulminant Viral Hepatitis

A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

a. rapid decreasing of liver size; and

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

c. rapid deterioration of liver function tests; and

d. deepening jaundice; and

e. hepatic encephalopathy.

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

22. Bacterial meningitis

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

23. Alzheimer's Disease

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

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

24. Cerebral aneurysm - with surgery or radiotherapy

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

i. Craniotomy
ii. Stereotatic radiotherapy
iii. Endovascular treatment by using coils to cause thrombosis (embolisation)

For the above definition the following are not covered:

i. Cerebral arteriovenous malformation.

25. Parkinson's disease - resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologis There must be permanent clinical impairment of motor function with either associated tremor or muscle rigidity.

For the above definition the following are not covered:

i. Parkinsonian syndromes/Parkinsonism

26. Pneumonectomy - Removal of an entire lung

The undergoing of surgery to remove an entire lung for disease or trauma.

The following is not covered:

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

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

27. Surgical removal of an eyeball

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

i. Self- inflicted injuries

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

D.II.BENEFITS UNDER THE POLICY:

D.II.1 Hospitalization Expenses:

We will cover the Medical Expenses of an Insured Person, in case of a Medically Necessary Hospitalization arising from a Disease/ Illness or Injury, provided such Medically Necessary Hospitalization is in India, for more than 24 consecutive hours and the admission date of the Hospitalization is within the Policy Period. We will pay Medical Expenses as shown in the Schedule for:

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

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

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

If the Insured Person is admitted in a room category that is higher than the one allowed under the Policy, then the Policyholder/ Insured Person shall bear the 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 to the room rent actually incurred.

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

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

D.II.2 Day Care Treatment:

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

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

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

D.II.3 Pre - hospitalization:

We will cover the Medical Expenses of an Insured Person, incurred towards a Disease/ Illness or Injury that occurs during the Policy Period and immediately prior to the Insured Person's date of Hospitalization.

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

Benefit under this cover is payable for maximum up to 60 days preceding the Hospitalization of the Insured Person and up to the Sum Insured[1]. Any claim under this section will reduce the Sum Insured.

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

D.II.4 Post - hospitalization:

We will cover the Medical Expenses of an Insured Person, incurred towards a Disease/ Illness or Injury that occurs during the Policy period and immediately post discharge of the Insured Person from the Hospital. The benefit is payable subject to hospitalization claim being admissible

under Section D.II.1 'Hospitalization Expenses' or Section D.II.2 'Day Care Treatment' and is related to the same Illness/condition.

Benefit under this cover is payable for maximum up to 180 days post discharge of the Insured Person from the Hospital and up to the Sum Insured[1]. Any claim under this section will reduce the Sum Insured.

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

D.II.5 Inpatient Hospitalization for AYUSH:

We will cover the Medical Expenses incurred towards the Insured Person in case of a Medically Necessary treatment taken during In-patient Hospitalization for AYUSH Treatment, for an Illness or Injury that occurs during the Policy Year, provided that:

1. Admission date of the Hospitalization is within the Policy Year.
2. The Insured Person has undergone AYUSH Treatment in a AYUSH hospital; where an AYUSH hospital is a healthcare facility wherein medical/ surgical/para-surgical treatment procedres and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospitals attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council of Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      a. Having at least 5 in-patient beds;
      b. Having qualified AYUSH Medical Practitioner in charge round the clock;
      c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      d. Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

The following exclusions will be applicable in addition to the other Policy exclusions:

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

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

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

D.II.6 Road Ambulance Cover:

We will cover the Reasonable and Customary expenses incurred 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 Policy, necessitating the Insured Person's admission to the Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

- Reasonable and Customary expenses shall include:
  i. Cost towards shifting an Insured person to the nearest hospital or
  ii. Costs towards transferring the Insured Person from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital; or
  iii. When the Insured Person requires to be moved to a better Hospital facility due to lack of super speciality treatment in the existing Hospital.

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

D.II.7 Donor Expenses:

We will cover the In-patient Hospitalization Medical Expenses towards the donor for harvesting the organ, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, – and under the following circumstances:

a. The organ donated is for the use of the Insured Person who has been prescribed to undergo an organ transplant on Medical Advice;
b. A claim is admissible under Section D.II.1 'Hospitalization Expenses', for the Insured Person;
c. We will not cover expenses towards any Pre or Post - hospitalization Medical Expenses towards the donor,
   i. Cost towards donor screening,
   ii. Cost associated to the acquisition of the organ,
   iii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.
   iv. Stem cell donation whether or not it is Medically Necessary treatment except for Bone Marrow Transplant.
   v. Expenses related to organ transportation or preservation.

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

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

D.II.8 Domiciliary Expenses

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

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

We will pay for pre hospitalization, post hospitalization medical expenses up to 60 days and 180 days respectively.

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

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

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

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

D.II.9. Adult Health Check-up

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

Network. This benefit will be available once a Policy Year starting from the first Policy Year.

Original copies of all reports will be provided to You.

Health Check-up list		
Sum Insured[1] (in INR)	**Age of the Insured Person at Policy year start date**	**List of tests**
50 Lacs/ 75 Lacs	18 to 35 years (Females)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH
50 Lacs/ 75 Lacs	18 to 35 years (Males)	Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
50 Lacs/ 75 Lacs	>35 years (Females)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, Uric acid, USG Abdomen & Pelvis
50 Lacs/ 75 Lacs	> 35 years (Males)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, PSA, Uric acid, USG Abdomen & Pelvis
100 Lacs/ 150 Lacs	18 to 35 years (Females)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, USG Abdomen & Pelvis
100 Lacs/ 150 Lacs	18 to 35 years (Males)	Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, USG Abdomen & Pelvis
100 Lacs/ 150 Lacs	> 35 years (Females)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, Uric acid, USG Abdomen & Pelvis, Sr. Electrolyte
100 Lacs/ 150 Lacs	> 35 years (Males)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, PSA, Uric acid, USG Abdomen & Pelvis, Sr. Electrolyte
200 Lacs/ 300 Lacs	18 to 35 years (Females)	Vitals, ECG, FBS, Kidney Profile, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, Thyroid Profile, USG Abdomen & Pelvis
200 Lacs/ 300 Lacs	18 to 35 years (Males)	Vitals, ECG, FBS, Kidney Profile, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, USG Abdomen & Pelvis
200 Lacs/ 300 Lacs	> 35 years (Females)	Vitals, FBS, HbA1C, Kidney Profile, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, TMT, Uric acid, USG Abdomen & Pelvis, Sr. Electrolyte
200 Lacs/ 300 Lacs	> 35 years (Males)	Vitals, FBS, HbA1C, Kidney Profile, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, TMT, PSA, Uric acid, USG Abdomen & Pelvis, Sr. Electrolyte

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

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

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

D.II.10 Robotic and Cyber Knife Surgery

We will cover the Medical Expenses incurred towards Medically Necessary Robotic or Cyber knife Surgery of the Insured Person subject to the Illness/ Injury being covered under Section D.II.1 'Hospitalization Expenses ' and the necessity being certified by an authorised Medical Practitioner.

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

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

D.II.11 Modern and Advanced Treatments

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

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

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

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

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

D.II.12 HIV/AIDS and STD Cover

We will cover the Medical Expenses incurred towards Medically Necessary treatment, taken during In-patient Hospitalization of the Insured Person, arising out of a condition caused by or associated to Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof or sexually transmitted diseases (STD).

The cover is available subject to below conditions:

i. The purpose of Hospitalization is to avail Medically Necessary Treatment.
ii. The necessity of the Hospitalization is certified by an authorised Medical Practitioner.
iii. For conditions other than STD, the Insured Person should be a declared HIV positive.
iv. We will pay for Pre-hospitalization and Post- hospitalization medical expenses maximum up to 60 days and 180 days respectively.

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

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

D.II.13 Mental Care Cover

We will cover the Medical Expenses incurred towards Medically Necessary treatment taken during In-patient Hospitalization of the Insured Person, arising out of a condition caused by or associated to a Mental illness, Stress, Anxiety, Depression or a medical condition impacting mental health.

The cover is available subject to below conditions:

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

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

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

D.II.14 Restoration of Sum Insured

We will provide for a 100% restoration of the Sum Insured[1] for any number of times in a Policy Year, provided that:

a. The Sum Insured is insufficient as a result of previous claims in that Policy Year.

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

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

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

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

f. If the Restored Sum Insured is not utilised in a Policy Year, it shall not be carried forward to subsequent Policy Year. For any single claim during a Policy Year the maximum Claim amount payable shall be up to the Sum Insured.

g. During a Policy Year, the aggregate indemnity claims amount payable, subject to admissibility of the claim, shall not exceed the sum of:

   i. The Sum Insured

   ii. Restored Sum Insured

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

D.II.15 Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers Permanent Partial Disablement, Permanent Total Disablement, death due to an injury caused by an Accident within 365 days from the date of the event or he/she is diagnosed with a Critical Illness, listed under this section, We will pay the next Renewal Premium of the Policy, for a policy tenure of 1 year. The premium shall be paid towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.

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

The cover is available subject to below conditions:

- If only one person is covered under the Policy, policy will not be renewed in case of death of the Policyholder.
- The Policyholder is not added in the Policy in the middle of the Policy Year.
- There is no change in covers, Sum Insured, benefit structure, limits and conditions applicable under the Policy, at the time of renewal.
- No new member is being added under the renewed Policy.
- In case of a policy with existing tenure of 2 or 3 years, it will be renewed only for one year, provided all the terms and conditions, benefits and policy limits remain same.

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

1. Cancer of Specified Severity -

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

II. The following are excluded -

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

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

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

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

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

   vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

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

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

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

   ii. New characteristic electrocardiogram changes

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

   The following are excluded:

   i. Other acute Coronary Syndromes

   ii. Any type of angina pectoris

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

3. Open Chest CABG -

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

II. The following are excluded:

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

4. Open Heart Replacement or Repair of Heart Valves -

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

5. Coma of specified severity -

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

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

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

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

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

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

6. Kidney Failure requiring regular dialysis -

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

7. Stroke resulting in permanent symptoms -

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

8. Major Organ/Bone Marrow Transplant -

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs -

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

10. Motor Neuron Disease with permanent symptoms -

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

11. Multiple Sclerosis with persisting symptoms -

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

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

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

II. Neurological damage due to SLE is excluded.

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

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

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

D.III OPTIONAL PACKAGES

D.III.1 HEALTH+:

This optional package is available to all Insured Persons covered under the Policy. Selection of this package is allowed at Policy level only. If opted, benefits under the package will be available for each Insured Person on individual basis, for individual as well as family floater policies.

D.III.1.iAir Ambulance Cover

We will cover the Reasonable and Customary expenses incurred towards transportation of an Insured Person, to the nearest Hospital or to move the Insured Person to and from healthcare facilities within India, by an Air Ambulance, provided that:

i. Air Ambulance is used during medical Emergency of the Insured Person;

ii. The Illness / Injury, causing Emergency, is covered under the Policy (under base cover). ;

iii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipments to monitor vitals and treat the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;

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

v. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the Insured Person's requirement for Air Ambulance;

vi. Payment under this cover is subject to a claim being admissible under Section D.II.1 'Hospitalization Expenses', for the same Illness/Injury;

vii. The benefit is available once in a Policy year for each Insured Person;

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

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

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

We will cover the expense towards Non-Medical items, listed under list I, Annexure III of the Policy and cost of buying or renting medical devices, prescribed to the Insured Person by the treating Medical Practitioner, during or after hospitalization for a Medically Necessary treatment.

The cover is available subject to below conditions:

i. Hospitalization claim is admissible under Section D.II.1 ' Hospitalization Expenses' and the expenses on Non-medical items or Medical devices are related to the same Illness/ Injury.

ii. The need for Medical device is prescribed by an authorised Medical Practitioner during hospitalization or within 180 days of post-hospitalization period.

Any purchase of the medical device should be done within 30 days of such recommendation.

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

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

Benefit under this cover is payable maximum up to Rs. 2 Lacs and once in 3 Policy Years. For the purpose of this benefit 'once' means one or more claims for Medically Prescribed medical device/s (listed above) provided that it is related to one Hospitalization. Claim under this section will not reduce the Sum Insured[1] and any balance amount, if not utilised will not be carried forward.

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

D.III.1.iii. Domestic Second Opinion

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

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

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

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

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

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

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

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

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

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

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

1. Cancer Treatment
2. Coronary Artery By-Pass Surgery
3. Heart Valve Replacement
4. Lung Transplant Surgery in case of End Stage Lung Disease
5. Kidney Transplant Surgery in case of End Stage Renal Failure
6. Liver Transplant Surgery in case of End Stage Liver Disease
7. Heart Transplant
8. Cardiac arrest (excluding angioplasty)
9. Bone Marrow Transplant
10. Neurosurgery
11. Surgical Treatment for Benign Brain Tumour
12. Pulmonary artery graft surgery
13. Aorta Graft Surgery
14. Stroke Treatment
15. Surgical treatment of Coma
16. Skin Grafting Surgery for Major Burns
17. Surgery for Pheochromocytoma
18. Permanent Paralysis of Limbs
19. Motor Neuron Disease with Permanent Symptoms
20. Multiple Sclerosis with Persisting Symptoms
21. Fulminant Viral Hepatitis
22. Bacterial meningitis
23. Alzheimer's Disease
24. Cerebral aneurysm - with surgery or radiotherapy
25. Parkinson's disease - resulting in permanent symptoms
26. Pneumonectomy - Removal of an entire lung
27. Surgical removal of an eyeball

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

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

D.III.1.iv. Bariatric Surgery Cover

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

The cover is available subject to below conditions:

i. Surgery is Medically Necessary and is certified by an authorised Medical Practitioner;

ii. Hospitalization is within the Policy Year.

iii. The Insured Person satisfies following criteria as devised by NIH (National Institute of Health):

a. The BMI should be greater than 37.5 without any co-morbidity; or greater than 32 with co-morbidity and

b. Is unable to lose weight through traditional methods like diet and exercise.

iv. This cover is available after a Waiting Period of 2 years from the inception of 'Health+ ' with Us, with respect to the Insured Person.

Benefit under this cover is payable maximum up to Rs. 5 Lacs and claim under this section will not reduce the Sum Insured[1].

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

D.III.1.v. Convalescence Benefit

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

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

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

D.III.1.vi. Major Illness Hospi Cash

If the Insured Person is hospitalised for a Medically Necessary treatment of a Major Illness, listed under the Policy, for each continuous and completed period of 24 hours of Hospitalization, We will pay daily cash benefit of Rs. 2,500 for maximum up to 10 days per hospitalization.

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

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

D.III.1.vii. Chemotherapy and Radiotherapy Cash

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

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

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

D.III.1.viii . Accidental Hospi Cash

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

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

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

D.III.1.ix. Domestic Concierge Services

If the Insured Person is hospitalised for a Medically Necessary treatment of an Illness/ Injury, covered under the Policy, We will offer assistance and support to You through Our concierge services.

For the purpose of this benefit, concierge services may include personal Hospital visit/s by Our representative, assistance in claim documentation and collection of documents at discharge, for speedy claim settlement.

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

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

For the complete list of locations, where the service is available, You may contact Our customer care services at customercare@manipalcigna.com or write to us at headcustomercare@manipalcigna.com or visit Our website.

D.III.1.x. Tele-Consultations

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

Any claim under this section will not reduce the Sum Insured[1].

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

D.III.2 WOMEN+

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

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

If opted, benefits under the package will be available to each eligible female on individual basis, for Individual as well as family floater policies.

D.III.2.i. Breast Cancer Screening

An annual Mammography screening will be available to each Insured female. The screening will be arranged by Us and conducted at Our Network.

Original copy of the report will be provided to You.

Claim under this Section will not reduce the Sum Insured[1].

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

D.III.2.ii. Cervical Cancer Screening

An annual papanicolaou screening, commonly known as pap smear will be available to each Insured female. The screening will be arranged by Us and conducted at Our Network.

Original copy of the report will be provided to You.

Claim under this section will not reduce the Sum Insured[1].

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

D.III.2.iii. Cervical Cancer Vaccination

We will pay the Reasonable and Customary Charges of vaccine incurred towards Cervical Cancer vaccination, as advised by the Medical Practitioner to the Insured Person. Cost of each dose of the vaccine will be limited up to Rs.2,500.

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

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

D.III.2.iv. Ovarian Cancer Screening

An annual Ovarian Cancer screening known as Ultrasound and CA 125 will be available to each Insured female. The screening will be arranged by Us and conducted at Our Network.

Original copy of the report will be provided to You.

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

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

D.III.2.v. Osteoporosis Screening

An annual Osteoporosis screening known as Dexa scan will be available to each Insured female. The screening will be arranged by Us and conducted at Our Network.

Original copy of the report will be provided to You.

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

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

D.III.2.vi. Gynaecological Consultations

Each Insured female may avail maximum up to 15 out-patient gynaecological consultations. These consultations will be arranged by Us and conducted at Our Network.

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

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

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

D.III.2.vii. Psychiatric and Psychological Consultations

Each Insured female may avail maximum up to 5 out-patient psychiatric/ psychological consultations and psychotherapy session. These consultations/ sessions will be arranged by Us and conducted at Our Network.

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

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

D.IV ADD ON - CRITICAL ILLNESS RIDER:

Along with this Product You can also avail the ManipalCigna Critical Illness Add On Cover (UIN: MCIHLIP21128V022021) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of applicable rider including medical check-up requirement will apply.

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

E. EXCLUSIONS

We shall not be liable to make any payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless otherwise covered or specified under the Policy or any Cover opted under the Policy. All the waiting period shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

E.I STANDARD EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

f. List of specific diseases/procedures:

i. Cataract,

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

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

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

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

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

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

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

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

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

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

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

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

This also includes:

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

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

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

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

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

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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

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

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

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

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

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

E.I.11 Excluded Providers Code - Excl 11

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

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

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

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

E.I.15 Refractive Error Code - Excl 15

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

E.I.16 Unproven Treatments Code - Excl 16

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

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

Expenses related to sterility and infertility. This includes:

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

E.I.18 Maternity Code Excl - 18

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

E.II SPECIFIC EXCLUSIONS

E.II.1 Personal Waiting period

A special Waiting Period not exceeding 48 months, may be applied to individual Insured Persons for the list of acceptable Medical Ailments listed under the Underwriting manual of the product depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

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

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

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

E.II.5 Treatment received outside India

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

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

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

E.II.9 Any form of Non-Allopathic Treatment, except Inpatient for AYUSH.

E.II.10 Existing diseases disclosed by the Insured Person (Limited to the extent of ICD codes mentioned in line with Chapter IV, Guidelines on Standardization of Exclusions in Health Insurance Contracts, 2019), provided the same is applied at the underwriting and consented by You/ Insured Person.

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

F. GENERAL TERMS AND CLAUSES

F.1 STANDARD GENERAL TERMS AND CLAUSES

F.I.1 Disclosure of Information

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 by the policyholder. (“ Material facts” for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

F.I.2 Condition Precedent to Admission of Liability

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

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

i. The Company shall settle or reject the claim, as the case may be within 30 days from the date of receipt of last necessary \document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it 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, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

"Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due

F.I.4 Moratorium period

After completion of eight continuous years under the policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

F.I.5 Complete Discharge

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

F.I.6 Multiple Policies

I. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases, the insurer chosen by the insured person 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.

II. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

III. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have right to choose insurer from whom he/she wants to claim the balance amount.

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

F.I.7 Free Look period

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

- The insured shall be allowed a period of fifteen days from the date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.
- If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a. a refund of the premium paid less any expenses incurred by Us on medical examination of the insured persons and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

F.I.8 Cancellation

i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation grid: (Applicable for Single and Yearly premium payment mode)

	Refund Grid as % of Premium		
Policy Cancellation Within	**Policy Year-1**	**Policy Year-2**	**Policy Year-3**
0-30 Days	85.00%	87.50%	89.00%
31-90 Days	75.00%	80.00%	82.50%
91-181 Days	50.00%	70.00%	75.00%
182-272 Days	30.00%	60.00%	70.00%
273-365 Days	0.00%	50.00%	60.00%
366-456 Days	NIL	35.00%	55.00%
457-547 Days	NIL	25.00%	45.00%
548-638 Days	NIL	15.00%	40.00%
639-730 Days	NIL	0.00%	30.00%
731-821 Days	NIL	NIL	25.00%
822-912 Days	NIL	NIL	15.00%
913-1003 Days	NIL	NIL	5.00%
1004 and more Days	NIL	NIL	0.00%

The above grid is applicable to policies issued with Premium Payment mode 'Single' or 'Yearly (with Policy Tenure 1 Year)'. For 'Yearly' premium payment mode with Policy Tenure 2/3 years, premium shall be refunded basis above grid for 'Policy Year- 1'.

No refund will be processed for cancellation of policies with Premium Payment Mode as Half-yearly, Quarterly or Monthly.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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

F.I.9 Migration

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

For Detailed Guidelines on Migration, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020.

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

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in

Your Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

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

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

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

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

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

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

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

F.I.11 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30/15 days, as applicable to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

F.I.12 Fraud

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

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

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

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

F.I.13 Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020 and Schedule I of IRDAI (health insurance) Regulations 2016 for the Portability norms.

F.I.14 Nomination:

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

F.I.15 Redressal of Grievance

In case of any grievance, the Insured Person may contact the Company with the details through:

Our website: www.manipalcigna.com

Email: customercare@manipalcigna.com

Senior Citizens may write to us at

Seniorcitizensupport@ManipalCigna.com

Toll Free : 1800-102-4462

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

Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at, 'The Grievance Cell, ManipalCigna Health Insurance Company Limited, 401/402, Raheja Titanium, Western Express Highway, Goregaon East, Mumbai-400063, India or or email - headcustomercare@manipalcigna.com.

For updated details of grievance officer, kindly refer link

https://www.manipalcigna.com/grievance-redressal

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

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

F.I.16 Withdrawal of Policy

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

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

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

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

F.II SPECIFIC TERMS AND CLAUSES

F.II.1 Geography

The geographical scope of this policy applies to events within India and all admitted or payable claims shall be settled in India in Indian rupees.

F.II.2 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

F.II.3 Terms and conditions of the Policy

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

F.II.4 No Constructive Notice

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

F.II.5 Records to be Maintained

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

F.II.6 Notice & Communication

- Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.
- No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.
- Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

F.II.7 Parties to the Policy

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

F.II.8 Dispute Resolution

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

F.II.9 Change of Policyholder

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

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

F.II.10 Limitation of Liability

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

F.II.11 Electronic Transactions

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

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

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

F.II.12 Endorsements (Changes in Policy)

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

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

- Rectification in Name of the Proposer / Insured Person
- Change of Policyholder
- Rectification in Gender of the Proposer/ Insured Person
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not impact the premium)
- Rectification in permanent address
- Change of occupation of the insured (if it does not change the risk class of insured)
- Change in height & weight of the insured (if it does not change the risk class of insured)
- Change/Updation in the contact details viz., Phone No., E-mail Id, etc.
- Updation of alternate contact address of the Proposer
- Change in Nominee Details
- Change in Claim Status (for cases where claims are reported post issuance of renewal notice and renewal policy issued before expiry date).

b) Financial Endorsements - which result in alteration in premium

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

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

F.II.13 Underwriting Loading & Special Conditions

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

We may apply a specific sub-limit on a medical condition/ailment depending on the past history and declarations or additional waiting periods (a maximum of 48 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy.

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

In case, You neither accept the counter offer nor revert to Us within the specified duration, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

F.II.14 Renewal Terms

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

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

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

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

e. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

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

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

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

i. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section E.I.1, E.I.2, E.I.3 & E.II.1 will be applicable considering such Policy Year as the first year of Policy with the Company.

j. In case of floater policies, children attaining 26 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits in the policy will remain intact.

F.II.15 You may pay the premium through National Automated Clearing House (NACH)/ Standing Instruction (SI) provided that:

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

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

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

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

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

F.II.16 Following discounts are available under the Policy:

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

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

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

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

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

All discounts under F.II.16 (a), (b), (d) and (e) are available to both individual as well as floater policies and (c) is available for Individual policies only.

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

F.II.17 Material Change

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

F.II.18 Alterations in the Policy

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

F.II.19 Grace Period

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

of cover

F.II.20 Premium calculation

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

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

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

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

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

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

If we receive any amount in excess of the required premium, we will refund the excess without paying any interest on the excess amount.

If we receive any amount lesser than the required premium, the same shall not be adjusted towards the premium and no interest shall be paid on the amount. You will not be entitled to any benefits or claims under the policy unless you pay the full premiums in time.

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

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

G OTHER TERMS AND CONDITIONS

G.I CLAIM PROCESS & MANAGEMENT

G.I.1 Condition Preceding

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

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

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

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

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

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

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

a. Forthwith intimate, file and submit the Claim in accordance to the Claim Procedure defined under Section G.I.3, G.I.4, and G.I.5 as mentioned below.
b. If so requested by Us, You or the Insured Person must submit himself/ herself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.
c. Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
d. Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

G.I.3 Claim Intimation

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

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

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

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

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

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

G.I.4 Cashless Facility

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

(a) For Planned Hospitalization:

i. The Insured Person should approach the Network provider at least 48 Hours days prior to the admission for Hospitalization
ii. The Network Provider will issue the request for authorisation letter prescribed by the IRDAI.
iii. The Network Provider shall electronically send the pre-authorisation form along with all the relevant details to the 24 (twenty-four) hour authorisation/cashless department along with contact details of the treating Medical Practitioner and the Insured Person.
iv. Upon receiving the pre-authorisation form and all related medical information from the Network Provider, we will verify the eligibility of cover under the Policy.
v. Wherever the information provided in the request is sufficient to ascertain the authorisation we shall issue the authorisation Letter

to the Network Provider. Wherever additional information or documents are required we will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 4 hours from the receipt of last complete documents.

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

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

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

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

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

iii. We shall accept or decline such additional expenses within 24 (twenty-four) hours of receiving the request for enhancement from You.

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

At the time of discharge:

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

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

(b) In case of Emergency Hospitalization

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

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

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

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

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

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

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

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

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

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

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

G.I.5 Claim Reimbursement Process

(a) Collection of Claim Documents

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

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

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

Health+ claim documents to be submitted in original:

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

Women+ claim document to be submitted in original:

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

- Claim form – filled and signed
- Doctor recommendation and consultation paper

- Payment receipt

For cashless process please refer Section G. I. 4.

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

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

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

G.I.6 Scrutiny of Claim Documents

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

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

c. We will send a maximum of 3 (three) reminders.

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

e. In case a reimbursement claim is received when a Pre-Authorisation letter has been issued for the same claim, before approving such claim a check will be made with the provider whether the Pre-authorisation has been utilised as well as whether the Policyholder has settled all the dues with the provider. Once such check and declaration is received from the Provider, the case will be processed

G.I.7 Claim Assessment

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

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

ii. The Claim amount assessed under Section G.I.7.i will be deducted from the Sum Insured.

1. Claim Assessment for benefit covers:

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

2. Claim process for Deductible plan:

If the claim amount is more than deductible, then final payable amount will be ascertained after all NME and room rent deduction, the claim will then be processed in two scenarios below:

- If this final payable amount is less than opted deductible, then claim will not be settled. The amount however will be calculated as aggregate for future claims.
- If final payable amount is more than opted deductible, then amount over and above deductible opted value will be paid.

3. Claim process for Restoration of Sum-insured:

For Restoration of sum-insured, Claims will be assessed as per regular cashless & reimbursement claim process. Once the sum-insured is exhausted, only for unrelated illness of the same member / any illness of another member, the restoration of sum-insured will be triggered. The restoration of sum-insured is post Our confirmation.

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

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

- In case of a claim (Cashless/Re-imbursement), an amount equivalent to the balance of the instalment premiums payable, in that policy year, would be recoverable from the admissible claim amount payable in respect of the Insured person.
- In case of a claim (Cashless/Re-imbursement), of amount equivalent or less then balance of the instalment premiums payable, in that policy year, would be recoverable first before the assessment of claim is made in respect of the claim intimated by the Insured person.

5. Emergency evacuation & Medical repatriation –

a. In the event of an Insured Person requiring Emergency evacuation and repatriation, Insured Person, must notify Us immediately either at Our call centre or in writing.

b. Emergency medical evacuations shall be pre-authorized by us.

c. Our team of Medical specialists in association with the Emergency Assistance Service Provider shall determine the Medical Necessity of such Emergency Evacuation or Repatriation post which the same will be approved. Hospi cash Benefit Claims.

All documents supporting the illness and /or hospitalization would be requested on case to case basis.

G.I.8 Claims Investigation

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

G.I.9 Pre and Post-hospitalization claims

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

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

G.I.10 Representation against Rejection

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

G.I.11 Payment Terms

- The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Benefit (s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.
- If You/ Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for “Any One Illness” under this Policy shall be applied as if they were under a single claim.
- For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.
- For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death, We will pay the nominee (as named in the Policy Schedule) and in case of no nominee to the Legal Heir who holds a succession certificate or Indemnity Bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of its liability under the Policy.

G.I.12 Deductible

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

b. Wherever such hospitalization claims as stated under G.I.12.

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

G.I.13 Domestic Second Opinion

a. Receive Request for Expert Opinion on major illness Insured person can submit his/her request for an expert opinion by calling Our call centre or register request through email.

b. Facilitating the Process

We will schedule an appointment or facilitate delivery of Medical Records of the Insured Person to a Medical Practitioner. The expert opinion is available multiple time in the event of the Insured Person being diagnosed with different major illness.

G.I. 14 Health Check-up, Screening, Consultation and Tele-Consultation

a. Insured Person shall seek appointment by calling Our call center.

b. We will facilitate his/her appointment and We will guide him/her to the nearest Network Provider for conducting the medical examination.

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

G.I.15 Claim Processing for Portability

For portability cases core claims system will validate credit period, pre-existing diseases & waiting period clauses during claims entry. Claims team will assess the claim as per regular cashless & reimbursement claim process.

G.I.16 Application of Multiple policies clause

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

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.

- In all such cases the insurer who has issued the chosen policy 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.
- Claims under other policy/polices may be made irrespective of exhaustion of Sum Insured in the earlier chosen policy / policies. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer (s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.
- 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.
- 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.

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

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

i) **Cashless hospitalization:** In case the Insured avails Cashless Facility for Hospitalization then Insured / Hospital will intimate us of the admission through a preauthorisation request with all details & estimated amount for the Hospitalization. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer (s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen. Post discharge, the hospital will send all the original documents to one of the insurer & certified copies of all documents to other insurers for settlement along with authorisation letter. The Company will evaluate the entire bill & arrive at the total payable amount & deduct the amount already settled by the other insurers & settle the difference payable amount to the hospital as per AL issued.

ii) **Reimbursement claim:** In case the Insured gets admitted & pays the entire bill & then files for reimbursement claim then he will have to intimate us of the admission 48 hours before admission for planned admissions & within 24 hours post admission for emergency hospitalization but in no case later than discharge from the Hospital. Insured will need to submit details of the other insurance policies to the Company. Post discharge insured will send all the original documents along with bills & claim form to one of the insurer & certified copies of all documents & bills along with duly filled claim form to the other insurers. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for theamounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer (s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

b) Retail policy & group policy from the Company:

i. **Cashless process:** In case the insured needs to utilize cashless facility for hospitalization then the insured / hospital will intimate the Company about the hospitalization through preauthorisation process. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer (s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen. Post discharge hospital will send as many separate claims as no. of policies with the Company with attached AL letters & original documents with the 1st claim & copy of documents with the other claims for settlement to the Company. The Company will settle all the claims as per policy terms & conditions & AL issued.

ii. **Reimbursement Claim process:** In case the Insured gets admitted & pays the entire bill & then files for reimbursement claim then he will have to intimate the Company of the admission 48 hours before admission for planned admissions & within 24 hours post hospitalization for emergency hospitalization along with all the policy numbers. Post discharge insured will send all original documents & bills along with duly filled claim form. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer (s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

G.II Annexure - I:

Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079-25501201/02/05/06 Email:- bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080-26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003 Tel.: 0755-2769201/202 Fax: 0755-2769203 Email:- bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar - 751 009. Tel.: 0674-2596461/2596455 Fax: 0674-2596429 Email:- bimalokpal.bhubaneswar@cioins.co.in	State of 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.: 0172-2706196/6468 Fax: 0172-2708274 Email:- bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044-24333668/24335284 Fax: 044-24333664 Email:- bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories- Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011-23232481/23213504 Email:- bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361-2132204/2132205 Email:- bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040-65504123/23312122 Fax: 040-23376599 Email:- bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.

JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141-2740363 Email:- bimalokpal.jaipur@cioins.co.in	State of Rajasthan.
KOCHI Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484-2358759/9338 Fax: 0484-2359336 Email:- bimalokpal.ernakulam@cioins.co.in	States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL.: 033-22124340/22124339 Fax: 033-22124341 Email:- bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522-2231330/1 Fax: 0522-2231310 Email:- bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022-26106552/6960 Fax: 022-26106052 Email:- bimalokpal.mumbai@cioins.co.in	State of Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai and Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P - 201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukkabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	States of Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	States of Maharashtra, Areas of Navi Mumbai and Thane but excluding Mumbai Metropolitan.

G.III Annexure - II:

Sr.no.	What am I covered for	India Plan
i	Sum Insured[1] (INR)	✓
ii	Sum Insured[2] (INR)	×
iii	Deductible (Optional) (INR)	5 Lacs /10 Lacs
Sr.no.	**Cover/s**	**India Plan**
1	Hospitalization Expenses	✓
2	Day Care Treatment	✓
3	Pre – hospitalization	✓
4	Post – hospitalization	✓
5	Inpatient Hospitalization for AYUSH	✓
6	Road Ambulance Cover	✓
7	Donor Expenses	✓
8	Domiciliary Expenses	✓
9	Adult Health Check-up	✓
10	Robotic and Cyber Knife Surgery	✓
11	Modern and Advanced Treatments	✓
12	HIV/AIDS and STD Cover	✓
13	Mental Care Cover	✓
14	Restoration of Sum Insured	✓
15	Premium Waiver Benefit	✓
Optional Packages		
I	**Health+** **(Each benefit is available on Individual Basis)** (Sum Insured/ limits specified under Health+ is over and above that of Base Plan (India Plan), as opted.	✓
II	**Women+** **(Available to female of age 12 years and above)** **(Each benefit is available on Individual Basis)** (Sum Insured/ limits specified under the Women+ is over and above that of Base Plan(India Plan), as opted.	✓
Add on cover (Rider) **This section lists the Add on cover available under your plan**		**Critical Illness:** Lump sum payment of Sum Insured, upon diagnosis of a Critical Illness.

G.IV Annexure - III:

LIST I - Items for which Coverage is not available in the Policy	
1.	BABY FOOD
2.	BABY UTILITIES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVEYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLTNDER (FOR USAGE OUTSTDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HTNGED)
46.	KNEE IMMOBILIZER/ SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE Tablets
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY
LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU.DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKETA/VARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES

31.	DAILY CHART CHARGES
32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES
LIST III- ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1.	HAIR REMOVAL CREAM
2.	DISPOSABLES RAZORS CHARGES (for site preparations)
3.	EYE PAD
4.	EYE SHEILD
5.	CAMERA COVER
6.	DVD, CD CHARGES
7.	GAUSE SOFT
8.	GAUZE
9.	WARD AND THEATRE BOOKING CHARGES
10.	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11.	MICROSCOPE COVER
12.	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13.	SURGICAL DRILL
14.	EYE KIT
15.	EYE DRAPE
16.	X-RAY FILM
17.	BOYLES APPARATUS CHARGES
18.	COTTON

19.	COTTON BANDAGE
20.	SURGICAL TAPE
21.	APRON
22.	TORNIQUET
23.	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV - ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1.	ADMISSION/REGISTRATION CHARGES
2.	Hospitalization FOR EVALUATION/ DIAGNOSTIC PURPOSE
3.	URINE CONTAINER
4.	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5.	BIPAP MACHINE
6.	CPAP/ CAPD EOUIPMENTS
7.	INFUSION PUMP_ COST
8.	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10.	HIV KIT
11.	ANTISEPTIC MOUTHWASH
12.	LOZENGES
13.	MOUTH PAINT
14.	VACCINATION CHARGES
15.	ALCOHOL SWABES
16.	SCRUB SOLUTION/STERILLIUM
17.	GLUCOMETER & STRIPS
18.	URINE BAG