Product Name: CignaTTK ProHealth Insurance
Insurance Company Name: CignaTTK Health Insurance Company Limited
Registered Office: 401/402, Raheja Titanium,
Western Express Highway, Goregaon (East),
Mumbai – 400063. IRDA Registration No. 151

CignaTTK ProHealth Insurance

Policy Terms and Conditions

I PREAMBLE & OPERATING CLAUSE

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

If any Claim arising as a result of a Disease/Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the Benefits in accordance with terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any).

BENEFITS UNDER THE POLICY

II BASIC COVERS

II.1. Inpatient Hospitalization:

We will cover Medical Expenses of an Insured Person in case of Medically Necessary Hospitalization arising from a Disease/ Illness or Injury provided such Medically Necessary Hospitalization is for more than 24 consecutive hours. 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 Category as per Plan opted and specified in the Schedule to this Policy.
b. Intensive Care Unit charges for accommodation in ICU ,
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.

Under the Protect, Plus & Accumulate Plans coverage is available up to a Single Private Room as defined in the Policy whereas with the Preferred and Premier Plan accommodation under any Room Category will be available excluding a suite.

If the Insured Person is admitted in a room category that is higher than the one that is specified in the Schedule to this Policy then the Policyholder/Insured Person shall bear a ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent of the entitled room category to the room rent actually incurred.

For the purpose of this Section “Associated Medical Expenses” shall include - Room Rent, Nursing Charges, Operation Theatre Charges, Fees of Medical Practitioner/Surgeon/ Anesthetist/ Specialist and Diagnostic Tests conducted within the same Hospital where the Insured Person has been admitted.

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

II.2. Pre - hospitalization:

We will, on a reimbursement basis cover Medical Expenses of an Insured Person which are incurred due to a Disease/ Illness or Injury immediately prior to the Insured Person's date of Hospitalisation up to limits specified in the Schedule, provided that a Claim has been admitted under In-patient Benefit under Section II.1 and is related to the same illness/condition.

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

II.3. Post - hospitalization:

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

All Claims under this benefit can be made as per the process defined under Sec tion VII 5.

II.4. Day Care Treatment:

We will cover payment of Medical Expenses of an Insured Person in case of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours Hospitalization due to advancement in technology and which is undertaken in a Hospital / nursing home/Day Care Centre on the recommendation of a Medical Practitioner. Any treatment in an outpatient department/OPD is not covered. For list of Day Care Treatments refer Annexure II of the Policy.

Coverage will also include pre-post hospitalisation expenses as available under the Plan opted.

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

II.5. Domiciliary Treatment:

We will cover Medical Expenses of an Insured Person which are towards a Disease/Illness or Injury which in the normal course would have required Hospitalisation 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. A Hospital bed was unavailable;

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

(a) If a claim has been accepted under this Benefit, the payment for Post-hospitalisation Medical Expenses shall not be payable.
(b) We will however pay for Pre-hospitalisation Medical Expenses up to 30 days in accordance with Section II.2 above.
(c) We shall not be liable under this Policy for any Claim in connection with or in respect of the following**:**

i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
ii. Arthritis, gout and rheumatism,
iii. Chronic nephritis and nephritic syndrome,
iv. Diarrhoea and all type of dysenteries, including gastroenteritis,
v. Diabetes mellitus and Insipidus,
vi. Epilepsy,
vii. Hypertension,
viii. Psychiatric or psychosomatic disorders of all kinds,
ix. Pyrexia of unknown origin.

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

II.6. Ambulance Cover:

a. We will provide for reimbursement of Reasonable and Customary expenses up to limits specified in the Schedule that are 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 in case of an Emergency, necessitating the Insured Person's admission to the Hospital . The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

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

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

II.7. Donor Expenses:

a. We will cover In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the Sum Insured, 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, provided that -

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

c. We have admitted a claim under Section II.1 – towards In-patient Hospitalization

d. We will not cover expenses towards the Donor in respect of:

i. Any Pre or Post - hospitalization Medical Expenses,

ii. Cost towards donor screening,

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

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

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

II.8. Worldwide Emergency Cover:

We will cover Medical Expenses of the Insured Person incurred outside India, up to limits specified in the Schedule, provided that:

(a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India and is payable under Section II.1 of the Policy.

(b)The Medical Expenses payable shall be limited to Inpatient Hospitalization only.

(c) Any payment under this Benefit will only be made in India, in Indian rupees on a re-imbursement basis and subject to Sum Insured. Cashless Facility may be arranged on a case to case basis. Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance In case where Cumulative Bonus accumulated is used for payment of claim under this benefit, the maximum liability under a single Policy year shall not exceed the Opted Sum Insured including Cumulative Bonus or Cumulative Bonus Booster as applicable.

(d) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

(e) You have given Us, intimation of such hospitalisation within 48 hours of admission.

(f) Any claim made under this Benefit will be as per the claims procedure provided under Clause VII.5 of this Policy.

(g) Exclusion VI.22 does not apply to this benefit.

All Claims under this benefit can be made as per the process defined under Section VII 5 & 18.

II.9. Restoration of Sum Insured:

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

(a) The Sum Insured inclusive of earned Cumulative Bonus (if any) or Cumulative Bonus Booster (if opted & earned) 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 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. No Restoration of the Sum Insured will be provided for coverage under Section II. 8. Worldwide Emergency Cover, Section II.11, New Born Baby Expenses Section II.12 and First Year Vaccinations Section II.13.

(d) The Restored Sum Insured will not be considered while calculating the Cumulative Bonus.
(e) Such restoration of Sum Insured will be available only once 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.
(f) If the Policy is issued on a floater basis, the Restored Sum Insured will also be available on a floater basis.
(g) If the Restored Sum Insured is not 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 sum of:
i. The Sum Insured
ii. Cumulative Bonus(if earned) or Cumulative Bonus Booster (if opted & earned)
(h) During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:
i. The Sum Insured
ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)
iii. Restored Sum Insured
All Claims under this benefit can be made as per the process defined under Section VII 4 & 5.

II.10. Health Maintenance Benefit:

(a) For Protect, Plus, Preferred & Premier Plans

We will cover, up to limits specific in the Schedule, by way of reimbursement the Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred on an Out Patient basis.

We will cover costs incurred towards:

i) Diagnostic tests, preventive tests, drugs, prosthetics, medical aids, prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule.

ii) Towards Dental Treatments and Alternative Forms of Medicines wherever prescribed by a Medical Practitioner.

Any unutilised Health Maintenance Benefit limit shall lapse at the end of the Policy Year and fresh limits will be available as per the Plan under the new Policy Year.

(b) For Accumulate Plan

We will cover, up to limits specified in the Schedule, by way of reimbursement the Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred on an Out Patient basis.

We will cover costs incurred towards:

i) Diagnostic tests, preventive tests, drugs, prosthetics, medical aids, prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule.

ii) Towards Dental Treatments and Alternative Forms of Medicines wherever prescribed by a Medical Practitioner.

Available Health Maintenance Benefit during the Policy Year can also be utilised towards payment of the deductible/co-pay/non payable component of a claim wherever opted and applicable including any cashless facility in case of a Hospitalization or Day Care Claim.
Unutilized HMB can continue to be carried forward each year as long as the Policy is renewed with Us in accordance with the Renewal Terms under the Policy.

All Waiting Periods and Permanent Exclusions including Co-pay's applicable on the Policy under Section V and VI shall not apply to this section. Any claim under this benefit shall not impact Cumulative Bonus.

All Claims under this benefit can be made as per the process defined under Section VII.14. . Further, all claims under this benefit will be subject to the any one claim limits specified under Section VII.15 of the Policy**.**

II.11. Maternity Expenses:

We will cover Maternity Expenses up to limits for Maternity Sum insured specified in the Schedule for the delivery of a child and/ or Maternity Expenses related to a Medically Necessary and lawful termination of pregnancy up to maximum 2 deliveries or terminations during the lifetime of an Insured Person between the ages of 18 years to 45 years.

You understand and agree that:

(a) Our maximum liability per delivery or termination is subject to the limits specified in the Schedule.

(b) The Insured Person should have been continuously covered under this Policy for at least 48 months before availing this Benefit, except in case of opting for 'Reduction in maternity waiting' where the limit will be relaxed to 24 months of waiting.

(c) The cover under this Benefit shall be restricted to two live children only.

(d) The payment towards any admitted claim under this Benefit for any complication arising out of or as a consequence of maternity or child birth will be restricted to limits specified in the Schedule however any restored amount will not be available for coverage under this section.

(e) Pre or post natal Maternity Expenses will be covered within the Maternity Sum Insured under this Benefit however; any Pre or Post – hospitalisation Expenses paid under Section II.2 and II.3, above will not be covered under this Benefit.

(f) Maternity Sum Insured available under Maternity Expenses will be in addition to Sum Insured.

(g) Applicable Deductible or Co-pay under the applicable plan shall also apply to this benefit. Any claim under this benefit shall not impact Cumulative Bonus.

(h) We will not cover the following expenses under Maternity Benefit:

i) Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.

ii) Medical Expenses for ectopic pregnancy. However, these expenses will be covered under the In-patient Hospitalisation under Section II.1.

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

II.12. New Born Baby Expenses:

Subject to a claim being admitted under Maternity Expenses Cover under Section II.11, We will cover.

(a) Medical Expenses towards treatment of the New Born Baby while the Insured Person is Hospitalised as an In-patient for delivery.

(b) The Reasonable and Customary Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits specified in the Schedule under Maternity Expenses without payment of any additional premium.

(c) Subject to the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby into the Policy by way of an endorsement or at the next Renewal, whichever is earlier.

Applicable Deductible or Co-pay under the applicable plan shall also apply to this benefit. Any claim under this benefit shall not impact Cumulative Bonus.

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

II.13. First Year Vaccinations

We will cover Reasonable and Customary charges for vaccination expenses for the New Born Baby as per National Immunization Scheme (India) listed below, till the baby completes 1 year (12 months) upto the limits specified in the Schedule. Any restored Sum Insured will not be available for coverage under this section.

We will continue to provide Reasonable and Customary charges for vaccination of the New Born Baby until it completes 12 months, if the Policy ends before the New Born Baby has completed one year subject however to the Policy being renewed in the subsequent year.

Time Interval	Vaccinations to be done (Age)	Frequency
0 – 3months	BCG (Birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2
3 – 6 months	OPV (14 week) OR OPV + IPV2	1 or 2
	DPT (14 week)	1
	Hepatitis-B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

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

III. VALUE ADDED COVERS:

III.1. Health Check Up:

(a) If the Insured Person has completed 18 years of Age, the Insured Person may avail a comprehensive health check-up with Our Network Provider as per the eligibility details mentioned in the table below. All Insured members above the age of 18 years will be eligible for a Health Check Up. Health Check Ups will be and arranged by Us and conducted at Our Network Providers. Any claim under this benefit shall not impact Cumulative Bonus.

For Protect & Accumulate Plan – Available once every 3rd Policy year

For Plus, Preferred and Premier Plan – Available once each year excluding the first policy year.

(b) Original Copies of all reports will be provided to You, while a copy of the same will be retained by Us**.**

Plan Name	**Sum Insured**	**Age**	**List of tests**
Protect	₹*2.5 Lacs,* ₹*3.5 Lacs,* ₹*4.5 Lacs,*	>18 years	MER, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, Urine Routine, SGPT
Plus	₹*4.5 Lacs,* ₹*5.5 Lacs,* ₹*7.5 Lacs,* ₹*10 Lacs*	18 to 40 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid
		> 40 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid For females only - TSH, Pap smear, Mammogram For Males only – PSA
Preferred & Premier	₹*15 Lacs,* ₹*30 Lacs,* ₹*50 Lacs,* ₹*100 Lacs*	18 to 40 years	MER, Lipid Profile, HbA1c, Sr. Creatinine, CBC-ESR, RUA, SGPT, ECG, SGOT, GGT, Uric Acid For females: Pap smear, TSH, Mammogram For males: PSA
		> 40 years (For males only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric acid, TMT, USG Abdomen & Pelvis, PSA

		> 40 years (For females only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, TMT, Uric acid, USG Abdomen & Pelvis, Pap smear, Mammogram, TSH
Accumulate	₹ *5.5 Lacs,* ₹ *7.5 Lacs,* ₹*10 Lacs*	>18 years	MER, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, Urine Routine, SGPT
	₹ 1*5 Lacs,* ₹ 20 *Lacs,* ₹ 25 *Lacs*	18 to 40 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid
	₹ 1*5 Lacs,* ₹ 20 *Lacs,* ₹ 25 *Lacs*	> 40 years	MER, Lipid Profile, HbA1c, Sr. Creatinine, CBC-ESR, RUA, SGPT, ECG, SGOT, GGT, Uric Acid For females: Pap smear, TSH, Mammogram For males: PSA

Full explanation of Tests is provided here: MER – Medical Examination Report, FBS – Fasting Blood Sugar, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT – Test Serum Glutamic Pyruvate Transaminase, HbA1C – Glycosylated Haemoglobin Test, RUA – Routine Urine Analysis, SGOT – Serum Glutamic Oxaloacetic Transaminase, TSH – Thyroid Stimulating Hormone, TMT – Tread Mill Test, USG – Ultrasound Sonography, PSA – Prostate Specific Antigen, Pap smear - Papanicolaou test

(c) Coverage under this value added cover will not be available on reimbursement basis. All Claims under this benefit can be made as per the process defined under Section VII. 16
(d) You understand and agree that the list of medical tests covered above are indicative and We may add, modify or amend this list on approval from the Head of Underwriting.

III.2. Expert opinion on Critical Illness:
You may choose to secure a second opinion from Our Network of Medical Practitioners, if an Insured Person is diagnosed with the covered Critical Illness during the Policy Period. The expert opinion would be directly sent to the Insured Person. Any claim under this benefit shall not impact Cumulative Bonus.

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

(a) We have received a request from You to exercise this option.
(b) That the expert opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner
(c) This benefit can be availed once by an Insured Person during a Policy Year and once during the lifetime of an Insured Person for the same Illness.
(d) This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
(e) The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.
(f) 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.
(g) The expert opinion under this Policy shall be limited to covered Critical Illnesses and not be valid for any medico legal purposes.
(h) 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.
(i) For the purpose of this benefit covered Critical Illnesses shall include –

- Cancer of specific severity
- First Heart Attack of specified severity

- Open Chest CABG
- Open Heart Replacement or Repair of Heart Valves
- Coma of specified severity
- Kidney Failure requiring regular dialysis
- Stroke resulting in permanent symptoms
- Major Organ/Bone Marrow Transplant
- Permanent Paralysis of Limbs
- Motor Neurone Disease with permanent symptoms
- Multiple Sclerosis with persisting symptoms

All Claims under this benefit can be made as per the process defined under Section VII.15.

III.3. Cumulative Bonus

a) On Sum Insured

We will increase Your Sum Insured as specified under the Plan opted at the end of the Policy Year if the Policy is renewed with Us provided that there are no claims paid/outstanding in the expiring Policy Year:

(a) If the Policy is a Family Floater Policy as specified in the Schedule, then the Cumulative Bonus will accrue only if no claims have been made in respect of all the Insured Persons in the expiring Policy Year.

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

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

(d) Any earned Cumulative Bonus will not be reduced for claims made in the future unless utilised.

(e) Wherever the earned Cumulative Bonus is used for payment of a claim during a particular Policy Year, the balance Cumulative Bonus if any will be carried forward to the next Policy Year.

(f) If the Policy Period is two/three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.

(g) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.

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

(i) If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

(j) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

(l) The Cumulative Bonus is provisional and is subject to revision if a Claim is made in respect of the expiring Policy Year, which is notified after the acceptance of renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.

(m) This clause does not alter Our right to decline a renewal or cancellation of the Policy for reasons as mentioned under Section VIII.16

b) On Health Maintenance Benefit for Accumulate Plan

We will provide a 5% Cumulative Bonus on the unutilized Health Maintenance Benefit limit (HMB) available at the end of the Policy Year irrespective of whether a claim is made on the expiring policy. This unutilized HMB limit plus the Earned Cumulative Bonus will get carried forward to the next Policy Year.

- Available HMB limit in the current Policy will be total of Unutilised HMB limit plus Earned Cumulative Bonus and the HMB limit of Current Policy Year.
- Each Year Cumulative Bonus will be calculated on the balance HMB value at the end of the year, irrespective of any change in Sum Insured or HMB opted on the Plan.
- Any earned Cumulative Bonus will not be reduced for claims made in the future.
  If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
- If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated HMB limit plus Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the HMB limit plus Cumulative Bonus that will be carried forward for credit in such Renewed Policy shall be the total of all the Insured Persons moving out.
- If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/individual policies then the Unutilised HMB limit plusCumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- Cumulative Bonus on the HMB limit shall not accrue if the Policy is not renewed with us within the Grace Period.

III.4. Healthy Rewards

You can earn reward points equivalent to 1% of premium paid including taxes and levies for each Policy. In addition to this You can accumulate rewards by opting for an array of Our wellness programs listed below, that will help You to assess Your health status and aid in improving Your overall well-being. Each specific program can be opted only once by a particular Insured Person. There will be no limitation to the number of programs one can enrol however maximum rewards that one can earn in a single policy period will be limited to 10% of premium paid in the existing Policy.

Details of reward points that can be accrued are listed below.

Program Type	Points to be earned as a percentage of previous Policy Period Premium
Health Risk Assessment (HRA)	0.50%
Targeted Risk Assessment (TRA)	0.50%
Online Lifestyle Management Program (LMP)	1%
Chronic Condition Management Programs	1%
Participating in CignaTTK Sponsored Programs and Worksite or Online/Offline Health Initiatives	Up to 2%
Health Check Up	0.5%

Reward Points, wherever offered under any specific Sponsored Program will be the same for all customers.

Each earned reward point will be valued at 1 Rupee. Accumulated reward points can be redeemed in the following ways –

- A discount in premium from 1st Renewal of the Policy.
- Equivalent value of Health Maintenance Benefit anytime during the policy.
- As equivalent value while availing services through our Network Providers as defined in the Policy.

IV. OPTIONAL COVERS

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

IV.1. Deductible:

We will provide for a Deductible on specific Sum Insured Options. Where ever a Deductible is selected such amounts will be applied for each Policy Year on the aggregate of all Claims in that

Policy Year other than for claims under fixed Benefit Covers, Health Maintenance Benefit and Health Check Ups. Any Voluntary Co-pay shall not apply to plans with Deductible option.
For the purpose of calculating the deductible and assessment of admissibility all claims must be submitted in accordance with Section VII.19 of Claims Process.
All other terms, conditions, waiting periods and exclusions shall apply.

IV.2. Reduction in Maternity Waiting:
We will provide for a waiver of waiting period for Maternity Expenses (Section II.11) from 48 months to 24 months from the date of inception of first Policy with Us.
New Born Baby cover and first year vaccinations will follow reduction in waiting period under Maternity Expenses Cover
All other terms, conditions and exclusions under Maternity Expenses Cover (Section II.11) shall apply.

IV.3. Voluntary Co-Pay:
Irrespective of the Age and number of claims made by the Insured Person and subject to the Co-payment option chosen by You, it is agreed that We will only pay 90% or 80% of any amount that We assess (payable amount) for the payment or reimbursement in respect of any Claim under the Policy made by that Insured Person and the balance will be borne by the Insured Person.
Co-pays shall not apply to Health Maintenance Benefit Health Check-Ups and the Critical Illness Add on (if opted).
Co-pay will be applied on the admissible claim amount. In case You have selected the Voluntary co-pay (Section IV.3), and/or if You chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction.

IV.4 Waiver of Mandatory Co-pay:
An option to remove Mandatory co-pay which is applicable for persons aged 65 years and above will be available on payment of additional premium.

IV.5. Cumulative Bonus Booster
We will provide an option to increase the Sum Insured by 25% for each claim free year up to a maximum of 100% when there are no claims paid or outstanding in the expiring Policy Year provided that the Policy is renewed with Us without a break.
- No cumulative bonus will be added if the Policy is not renewed with Us by the end of the Grace Period. The Cumulative Bonus will not be accumulated in excess of 100% of the Sum Insured under the current Policy with Us.
- Any earned Cumulative Bonus will not be reduced for claims made in the future. Wherever
- the earned Cumulative Bonus is used for payment of a claim during a particular Policy Year, the balance Cumulative Bonus if any will be carried forward to the next Policy Year.
- In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III. (iii) shall not be available, however all terms and conditions of the said section shall apply.
- This Cumulative bonus shall not be available for claims made for Maternity Expenses under Section II.11, New Born Baby Expenses Section II.12 and First Year Vaccinations Section II.13

V. WAITING PERIODS

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

V.1. Pre-existing Disease Waiting Period
All Pre-existing Diseases / Illness / Injury / conditions as defined in the Policy, until 24/ 36/ 48 (as specified in the Schedule) months of continuous covers have elapsed since inception of the first Policy with Us. This exclusion doesn't apply for Insured Person having any health insurance indemnity policy in India at least for a period of 12/24/36/48 months as applicable, prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

V.2. 30 days Waiting Period

Any disease contracted and/or Medical Expenses incurred in respect of any Pre-existing Disease/Illness by the Insured/Insured Person during the first 30 days from the inception date of the Policy will not be covered.

This exclusion doesn't apply for Insured Person having any health insurance indemnity policy in India at least for a period of 30 days prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

V.3. Two year waiting period

A waiting period of 24 months shall apply to the treatment, of the following, whether medical or surgical for all Medical Expenses along with their complications on treatment towards:

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.

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

V.4. Maternity Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 48 months of continuous coverage has elapsed for the particular Insured Person since the inception of the first Policy with Us. However, this exclusion / waiting period will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

Wherever Optional Cover for 'Reduction in Maternity Waiting Period' has been applied this limit will be reduced to 24 months of continuous cover.

V.5. 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 Policy Clause VIII.20.Loadings & Special Conditions, 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.

VI PERMANENT EXCLUSIONS

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

1. Genetic disorder and stem cell implantation/surgery, harvesting, storage or any kind of treatment using stem cells.

2. Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
3. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
4. Birth control procedures, contraceptive supplies or services including complications arising due to supplying services, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception, surrogate or vicarious pregnancy.
5. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, cochlear implants, vaccinations except post-bite treatment or for new born baby up to 90 days, any physical, psychiatric or psychological examinations or testing , any treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall treatment & products, issue of medical certificates and examinations as to suitability for employment or travel.
6. Laser Surgery for treatment of focal error correction other than for focal error of +/- 7 or more and is medically necessary.
7. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
8. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
9. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
10. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
11. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
12. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD)
13. Treatment for general debility, ageing, convalescence, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, ,run down condition or rest cure, congenital external anomalies or defects, sterility, fertility, infertility including IVF and other assisted conception procedures and its complications, subfertility, impotency, venereal disease, puberty, menopause or intentional self-injury, suicide or attempted suicide(whether sane or insane).
14. Certification / Diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven, or any form of clinical trials or any kind of self-medication and its complications.
15. Ailment requiring treatment due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation.
16. Any illness or hospitalization arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.
17. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
18. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
19. 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.

20. Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganization of personality or mind, or emotions or behaviour, including stress, Parkinsons or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition").
21. Any cosmetic surgery, aesthetic treatment unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity/morbid obesity (unless certified to be life threatening) or treatment/surgery /complications/illness arising as a consequence thereof.
22. Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses.
23. Any robotic, remote surgery or treatment using cyber knife.
24. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital.
25. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
26. Any form of Non-Allopathic treatment, Naturopathy, hydrotherapy, Ayurvedic, Homeopathy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.
27. Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.
28. Insured Person whilst flying or taking part in aerial activities (including cabin) except as a fare-paying passenger in a regular scheduled airline or air Charter Company.
29. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
30. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
31. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.
    For complete list of Non-medical expenses, Please refer to the Annexure IV "Non-Medical Expenses".
32. Non-Medical Expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the hospital under whatever head, registration/admission charges.
33. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.
34. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

VII. CLAIM PROCESS & MANAGEMENT

VII.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.

VII.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 VII.3, VII.4, VII. 5 as mentioned below.
(b) Follow the directions advice or guidance provided by a Medical Practitioner. We shall not be obliged to make any payment(s) that are brought about or contributed to, as a consequence of failure to follow such directions, advice or guidance.
(c) 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.
(d) Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
(e) Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

VII.3. Claim Intimation
Upon the discovery or occurrence of any Illness / Injury that may give rise to a Claim under this Policy, You / Insured Person shall undertake the following:

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a claim covered under the Policy, You/the Insured Person, must notify Us either at the call center or in writing, in the event of:
• Planned Hospitalization, You/the Insured Person will intimate such admission at least 3 days prior to the planned date of admission.
• Emergency Hospitalization, You /the Insured Person will intimate such admission within 48 hours of such admission.
The following details are to be provided to Us at the time of intimation of Claim:
• Policy Number
• Name of the Policyholder
• Name of the Insured Person in whose relation the Claim is being lodged
• Nature of Illness / Injury
• Name and address of the attending Medical Practitioner and Hospital
• Date of Admission
• Any other information as requested by Us

VII.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 at least 3 days prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.
ii. The Network Provider will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDA.
iii. The Network Provider shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty four) hour authorization/cashless department along with contact details of the treating Medical Practitioner and the Insured Person.
iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.
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 sanctioned amount, any specific limitation on the claim, any co-pays or deductibles and non-payable items if applicable.
vii. The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorization.

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

i. The Network Provider shall request Us for an enhancement of authorisation limit as described under Section VII.4 (a) including details of the specific circumstances which have led to the need for increase in the previously authorized limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
ii. We shall accept or decline such additional expenses within 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 VII.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 VII.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 Hospitalisation

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 48 hours of admission to the Hospital as per the process under Section VII.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 and shall not be available to the Insured Person for coverage under Worldwide Emergency Cover (Section II.8) 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 –

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

VII.5. Claim Reimbursement Process

(a) Collection of Claim Documents

i. Wherever You have opted for a reimbursement of expenses, You may submit the following documents for reimbursement of the claim to Our branch or head office at your own expense not later than 15 days from the date of discharge from the Hospital. You can obtain a Claim Form from any of our Branch Offices or download a copy from our website www.cignattkinsurance.in
ii. List of necessary claim documents to be submitted for reimbursement are as following:

Claim form duly signed
Copy of photo ID of patient
Hospital Discharge summary
Operation Theatre notes
Hospital Main Bill
Hospital Break up bill
Investigation reports

Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Doctors reference slip for investigation
Pharmacy Bills
MLC/ FIR report, Post Mortem Report if applicable and conducted
KYC documents (Photo ID proof, address proof, recent passport size photograph)
Cancelled cheque for NEFT payment
Payment receipt.

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

iii. Our branch offices shall give due acknowledgement of collected documents to You.

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

VII.6. Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents. Any deficiency of documents, shall be intimated to You 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 You of the same and every 10 (ten) days thereafter.
c. We will send a maximum of 3 (three) reminders.
d. We may at our sole discretion decide to deduct the amount of claim for which deficiency is intimated to the insured person and settle the claim if we observe that such a claim is otherwise valid under the policy.
e. In case a reimbursement claim is received when a Pre-Authorization letter has been issued, before approving such claim a check will be made with the provider whether the Pre-authorization has been utilized as well as whether the Policyholder has settled all the dues with the provider. Once such check and declaration is received from the Provider, the case will be processed.

VII.7. Claim Assessment

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

a) For Plans without Deductible Option

i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.
ii) Any Voluntary or Mandatory Co-payment shall be applicable on the amount payable after applying the Section VII.7 a (i)
iii) If the provisions of the Contribution Clause apply, (under Section VIII.10), Our liability to make payment under the claim shall be apportioned accordingly after applying the Section VII7.a(i) and (ii).

b) For Plans with Deductible Option

i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.
ii) Arrived payable claim amount will be assessed against the deductible.

iii) Any Mandatory Co-payment shall be applicable on the amount payable after applying the Section VII.7 b (i), (ii)

iv) If the claim amount is higher than the deductible, and if the provisions of the Contribution Clause apply, (under Section VIII.10), Our liability to make payment under the claim shall be apportioned accordingly. Where the claim amount is within the Deductible we will not apply the Contribution Clause (under Section VIII.10.) after applying the Section VII.7 b (i), (ii) & (iii)

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

i) Deductible & Co-pays (if opted)
ii) Mandatory Copay s (if applicable)
iii) Sum Insured
iv) Cumulative Bonus
v) Restored Sum Insured

VII.9. 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 6 months from the date of receipt of claim intimation. Verification carried out, if any, will be done by individuals or entities authorised by Us to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by the Us.

VII.10. 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 hospitalisation 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.

VII.11. Settlement & Repudiation of a claim

We shall settle a Claim including its rejection within 30 days of the receipt of the last “necessary” documents.

In case of suspected frauds, the last “necessary” document shall mean the receipt of verification/investigation report to determine the validity of the claim as stated in VII.9.above.

In the cases of delay in the payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

VII.12 Representation against Rejection:

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

VII.13. Claims falling in 2 policy periods

If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period. The admissible claim amount shall be reduced to the extent of premium to be received for the Renewal/due date of premium of health insurance policy, if not received earlier. In case of a Claim under Maternity Expenses the Maternity Sum Insured under the first Policy will be the maximum limit available.

VII.14. Payment Terms

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

We are not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if You/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by You/Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
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.

Claim process Applicable to the following Sections:

VII.15. Health Maintenance Benefit

(a) Submission of claim

You can send the Health Maintenance Benefit claim form along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by You/ Insured Person as the case may be, to Our branch office or Head Office at your own expense. The Health Maintenance Benefit under all Plans can be claimed only once during the Policy Period up to the extent of limit under this benefit or a maximum of Rs 15000.
Where a claim for Health Maintenance Benefit exceeds Rs 15,000 for a single claim the same can be claimed at any time during the Policy Period.
In respect of Health Maintenance Benefit under the Accumulate Plan which is utilised for payment of opted Deductible or Co-pay the same can be settled along with the claim under the respective sections wherever applicable.

(b) Assessment of Claim Documents

We shall assess the claim documents and assess the admissibility of claim subject to terms and conditions of the Policy .

(c) Settlement & Repudiation of a claim

We shall settle claims, including its rejection, within 5 (five) working days of the receipt of the last 'necessary' document but not later than 30 days.

VII.16. Expert Opinion on Critical Illness

(a) Receive Request for Expert Opinion on Critical Illness

You can submit Your request for an expert opinion by calling Our call centre or register request through email.

(b) Facilitating the Process

We will schedule an appointment or facilitate delivery of Medical Records of the Insured Person to a Medical Practitioner. The expert opinion is available only in the event of the Insured Person being diagnosed with Covered Critical Illness.

VII.17. Health Check up

(a) You or The Insured Person shall seek appointment by calling Our call centre.
(b) We will facilitate Your appointment and We will guide You to the nearest Network Provider for conducting the medical examination. Reports of the Medical Tests can be collected directly from the centre. A copy of the medical reports will be retained by the medical centre which will be forwarded to Us along with the invoice for reimbursement.

VII.18. Worldwide Emergency Cover

a) In an unlikely event of You or the Insured Person requires Emergency medical treatment outside India, You or Insured Person, must notify Us either at Our call centre or in writing within 48 hours of such admission.
b) You shall file a claim for reimbursement in accordance with Section VII.5 of the Policy.

VII.19. Deductible

a) Any claim towards hospitalisation during the Policy Period must be submitted to Us for assessment in accordance with the claim process laid down under Section VII.4 and Section VII.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 VII.6. and VII. 7.b).
b) Wherever such hospitalisation claims as stated under VII.19. 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.

VIII. GENERAL TERMS AND CONDITIONS

VIII.1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration, claim form declaration, medical history on the claim form and connected documents, or any material information having been withheld by You or any one acting on Your behalf, under this Policy. You further understand and agree that We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us.

VIII.2. Material Change

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

VIII.3. Observance of Terms and Conditions

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

VIII.4. Reasonable Care

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

VIII.5. Alterations in the Policy

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

VIII.6. Change of Policyholder

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

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

VIII.7. No Constructive Notice

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

VIII.8. Geography

The geographical scope of this policy applies to events within India other than for Worldwide Emergency Cover and which are specifically covered in the Schedule. However all admitted or payable claims shall be settled in India in Indian rupees.

VIII.9. Subrogation

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

VIII.10. Contribution

The contribution clause will apply for the following condition as detailed below and limited only to indemnity sections -

If two of more policies are taken by You during the same period from one or more Insurers to indemnify treatment costs and the amount of claim is within the Sum Insured limit of any of the policies, You will have the right to opt for a full settlement of Your claim in terms of any of Your policies.

Where the amount to be claimed exceeds the Sum Insured under a single policy after considering Deductibles, Co-pays (if applicable), You can choose the insurer with which You would like to settle the claim. Wherever We receive such claims We have the right to apply the Contribution clause while settling the claim.

VIII.11. Mandatory Co-pay

A compulsory Co-payment of 20% is applicable on all claims for Insured Persons aged 65 years and above irrespective of age of entry in to the Policy. For persons who have opted for a Waiver of Mandatory Co-pay the same will not apply.

Co-pay will be applied on the admissible claim amount. In case the Insured has selected the Voluntary co-pay (Section IV.3), and/or if he chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction.

VIII.12. Multiple Policies

In case of two or more policies taken by an Insured Person during a period from one or more insurer, the Contribution Section under VIII.10 shall not apply where the cover/benefit offered:

- Is fixed in Nature
- Does not have any relation to the treatment costs/same Illness

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

VIII.13. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

VIII.14. Records to be maintained

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

VIII.15. Free Look period

A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. The Insured has the option of cancelling the Policy stating the reasons for cancellation. If there are no claims reported (paid/outstanding) under the Policy then We shall refund the full premium after retaining 50% of costs for any medical tests if conducted. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

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

VIII.16. Cancellation

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

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

	Refund		
In force Period-Up to	**1 Year**	**2 Year**	**3 Year**
1 Month	75.00%	85.00%	90.00%
3 months	50.00%	75.00%	85.00%
6 months	25.00%	60.00%	75.00%
12 months	NIL	50.00%	60.00%
15 months		30.00%	50.00%
18 months		20.00%	35.00%
24 months		NIL	30.00%
30 months			15.00%
30+ months			NIL

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

An individual policy with a single insured shall automatically terminate in case of Your death or if You are no longer a resident of India. In case of an Individual Policy with multiple Insured Persons and in case of a floater, the Policy shall continue to be in force for the remaining members of the family up to the expiry of current Policy Period. The Policy may be Renewed on an application by another adult Insured Person under the Policy whenever such is due. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with You) must be given to Us along with the Application.

All coverages and benefits including any earned Healthy Reward Points under the Policy shall automatically lapse upon cancellation of the Policy.

Wherever a Policy under the Accumulate Plan is cancelled, any unclaimed Health Maintenance Benefit limit will remain applicable on the Policy and available for a claim over the next 12 month period. You may convert any available Healthy Reward Points in to the Health Maintenance Benefit before initiating the cancellation of the Policy.

VIII.17. Grace Period

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an 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.

VIII.18. Renewal Terms

a. The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium
b. The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous policy expiry date and current Policy start date. We, however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-existing Condition. . In case of Accumulate Plan only the unutilised Health Maintenance Benefit limit (excluding any Cumulative Bonus) will be available for a claim during the grace period Where the Policy is not renewed before the end of the Grace Period and the Policy is terminated, any unutilized Health Maintenance Benefit limit in respect of the Accumulate Plan shall be available for a claim as defined under II.X. above up to a period of 12 months from the date of expiry of the Policy. All Such claims will be in respect of the Insured Members under the expiring policy only.
c. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by You.
d. Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDA.
e. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.
f. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDA and in accordance with the IRDA 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 3 months prior to date of such revision or modification.
g. Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of members, addition deletion of Medical Condition 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 changes on renewal. The terms and conditions of the existing policy will not be altered.
h. Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as

mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.

i. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 48/ 36/ 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.
j. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section V.1 to V.5 will be applicable considering such Policy Year as the first year of Policy with the Company.
k. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.
l. Once an Insured Person attain age of 65 years on renewal a Mandatory co-payment of 20% will be applicable on all claims irrespective of the age of entry in to the Policy. This clause does not apply to persons who have opted for a Waiver of Mandatory Co-pay.
m. In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Cumulative Bonus earned on the Policy will stay with the floater cover.

VIII.19. Premium calculation

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

Zone Classification

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

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Gujarat

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

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

(a) Persons paying Zone I premium can avail treatment all over India without any Co-pay.
(b) Persons paying Zone II premium
i) Can avail treatment in Zone II and Zone III without any Co-pay.
ii) Availing treatment in Zone I will have to bear 10% of each and every claim.
(c) Person paying Zone III premium
i) Can avail treatment in Zone III, without any Co-pay.
ii) Availing treatment in Zone II will have to bear 10% of each and every claim.
iii) Availing treatment in Zone I will have to bear 20% of each and every claim.
***Option to select a Zone higher or lower than that of the actual Zone is available on payment of applicable premium at the time of buying the First Policy and on subsequent renewals

Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to Accident. The aforesaid Co-payments applicable are in addition to the Voluntary Co-pay under Section IV.3 (if opted) and Mandatory Co-pay under Section IV.4 (if applicable) and will be applied in conjunction to Section IV.3 and Section IV.4 of the Policy.

Premium towards Maternity Expenses, New born baby expenses and First Year Vaccinations shall be applied to female Insured Members between age group of 18 to 45 years only.

VIII.20. Loadings & 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 on pre-existing diseases as part of the special conditions on the Policy. Details of applicable loadings by ailments/ medical test results are listed as below along with the applicable sub-limits and waiting periods..
We shall inform You about the applicable risk loading or special condition through a counter offer letter and You would need to revert with consent and additional premium (if any), within 7 working days of the issuance of such counter offer letter.

In case, You neither accept the counter offer nor revert to Us within 7 working days, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.
Following loadings may be applied on the policy for the medical conditions listed below if they are accepted at the time of underwriting. The loadings are applicable on individual ailments only. Maximum Risk Loading per individual shall not exceed 100% of Premium excluding Statutory Levis and Taxes.

Sr. No.	List of Acceptable Medical Ailments(subject to other co-existing conditions, age, duration of ailment and whether treatment is ongoing or compelted)	Applicable Underwriting Loading Percentage on Premium
1	Anal fistula	5
2	Anemia, Hemolytic	10
3	Asthma	10
4	Benign Prostatic Hyperplasia	10
5	Biliary stones	10
6	Cataract (if surgery not done)	7.5
7	Cholelithiasis	10
8	Deviated Nasal Septum	7.5
9	Diabetes Mellitus	15
10	Dyslipidemia	7.5
11	Epilepsy	15
12	Fatty Liver	5
13	Fibro adenoma breast (non-malignant)	5
14	Fissure in Ano	5
15	GERD (Gastric Esophageal Reflux Disease)	10
16	Hematuria	10
17	Hemorrhoids	7.5
18	Hydrocele	10
19	Hypertension	15
20	Inguinal Hernia	7.5
21	Leiomyoma of GI tract	15
22	Myoma Uterine	10
23	Nasal polyp	7.5
24	Ovarian Cysts	5
25	Peptic Ulcer Diseases	7.5
26	Poliomyelitis	10
27	Polycystic Ovarian Disease (PCOD)	10

28	Renal stones	7.5
29	Tuberculosis	10
30	Tympanoplasty	5
31	Umbilical hernia	7.5
32	Undescended Testicle	5
33	Urinary Tract infection (UTI) / kidney infection	15
34	Varicocele	10
35	Varicose Veins	15
36	Vertigo	15

S.No.	Medical Test	Range of Loading Percent (For more than 10 percentile deviation from normal test values)
1	Haemogram	10
2	Blood Sugar	10
3	Urine routine	10
4	Kidney Function Test	10
5	Complete Lipid Profile	10
6	Liver Function Test	10
7	Carcino Embryonic Antigen	In case of deviation from normal values, proposal will be declined.
8	Prostate Specific Antigen	In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis.
9	Thyroid Profile	10
10	C Reactive Protein	10
11	Tread Mill Test	In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis.
12	USG Abdomen & Pelvis	In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis.
13	X-Ray Chest	In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis.
14	HIV	In case of deviation from normal values, proposal will be declined.
15	Hepatitis B Surface Antigen	In case of deviation from normal values, proposal will be declined.
16	Pap Smear	In case of deviation from normal values, proposal will be declined.
17	2D Echo	In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis.

Normal Test Values will be as per the medical test reports provided in the reports.

Personal Waiting Periods for Ailments declared or Diagnosed at the time of Pre-acceptance Medical Tests:

Personal Waiting Periods: Applicable Plan Wise for the specific listed medical conditions.

Range of Waiting Period (in yrs) Applicable for Pre Existing Disease for Pro Health Plan				
S.No.	**List of Acceptable Medical Ailments**	**Protect & Accumulate Plan**	**Plus Plan**	**Preferred/ Premier Plan**
1	Asthma	NA	4	4

2	Benign Prostatic Hyperplasia	NA	4	3
3	Biliary stones	NA	4	3
4	Cataract	NA	4	3
5	Cholelithiasis	NA	4	3
6	Diabetes Mellitus	NA	4	4
7	Epilepsy	NA	4	4
8	Fibroadenoma breast	NA	4	3
9	Fissure in Ano	NA	4	4
10	GERD (Gastric Esophageal Reflux Disease)	NA	4	4
11	Hemorrhoids	NA	4	4
12	Hypertension	NA	4	4
13	Inguinal Hernia	NA	4	3
14	Leiomyoma of GI tract	NA	4	4
15	Myoma Uterine	NA	4	3
16	Ovarian Cysts	NA	4	3
17	Peptic Ulcer Diseases	NA	4	4
18	Polycystic Ovarian Disease (PCOD)	NA	4	4
19	Renal stones	NA	4	3
20	Tuberculosis	NA	4	3
21	Umbilical hernia	NA	4	3
22	Undescended Testicle	NA	4	4
23	Urinary Tract infection (UTI) / kidney infection	NA	4	4
24	Varicose Veins	NA	4	3
25	Vertigo	NA	4	3

Additional Sub-limit applied on Special Conditions: The Policy will pay only 75% of the payable claim amount arising out of the specified illness/medical condition as listed above and its complications as declared by the Insured Person or diagnosed at the time of pre-acceptance medical tests. Admissible claim amount will be calculated after apply all the co-pays applicable under the Policy have been accounted. This condition will be applicable for a maximum of 48 months from the date of inception of first policy.

VIII.21. Communications & Notices

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

a. The policyholder's, at the address as specified in Schedule
b. To Us , at the address specified in the Schedule.
c. No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.
d. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

VIII.22. 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.

VIII.23. Overriding Effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

VIII.24. Fraudulent Claims

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

VIII.25. 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.

VIII.26. Portability & Continuity Benefits

You can port Your existing health insurance policy from another company to ProHealth Insurance, provided that:

a. You have been covered under an Indian retail health insurance policy from a Non-life Insurance company registered with IRDA without any break in the immediate previous policy.
b. We should have received Your application for Portability with complete documentation at least 45 days before the expiry of Your present period of Insurance
c. If the Sum Insured under the previous Policy is higher than the Sum Insured chosen under this Policy, the applicable waiting periods under Sections V.1, V.2, V.3, V.4, and V.5 shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the Eligible Cumulative Bonus under the expiring health insurance policy.
d. In case the proposed Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods under Sections V.1,V.2, V.3, V.4, and V.5 shall be applicable afresh to the amount by which the Sum Insured under this Policy exceed the total of sum insured and Eligible Cumulative Bonus under the expiring health insurance policy;
e. All waiting periods under Sections V.1, V.2, V.3, V.4, and V.5 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
f. If You were covered on a floater basis under the expiring Policy and apply for a floater cover under this Policy, then the Eligible Cumulative Bonus to be carried forward on this Policy shall also be available on a floater basis.
g. If You were covered on an individual basis in the expiring Policy then the Eligible Cumulative Bonus to be carried forward on this Policy shall be available on an individual basis.

For the purpose of this provision, Eligible Cumulative Bonus shall mean the Cumulative Bonus which You or the Insured Person would have been eligible for had the same policy been Renewed with the existing insurance company.

It is further agreed and understood that

a. Portability benefit will be offered to the extent of sum of previous sum insured and accrued cumulative bonus (if opted for), and Portability shall not apply to any other additional increased Sum Insured.
b. We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.
c. There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation
d. We should have received the database and claim history from the previous insurance company for Your previous policy.

The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals. All benefits under the Policy will terminate on successful porting of the Policy other than any Health Maintenance Benefit under Accumulate Plan which will be available for a claim up to a period of 12 months from the date of expiry of such policy.

In case You have opted to switch to any other insurer under portability provisions and the outcome of acceptance of the portability request is awaited from the new insurer on the date of renewal,

a. We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis.
b. If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternately We may deduct the premium for the balance period and pay the balance claim amount if any and issue the Policy for the remaining period.

VIII.27. Complete Discharge

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

VIII.28. 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.

VIII.29. Grievances Redressal Procedure

If you have a grievance that you wish us to redress, you may contact us with the details of the grievance through:

Our website: <<Website>>
Email: <<Email ID>>
Toll Free : <<Number>>
Fax: <<Will be added once available>>
Courier: Any of Our Branch office or corporate office during business hours.

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

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may contact Our Head of Customer Service at The Grievance Cell, CignaTTK Health Insurance Company Limited, <<Address>> or email <<email of head of customer service>>.

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

IX Definitions

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

2. **Age** or Aged is the age last birthday, and which means completed years as at the Inception Date

3. **Alternative Treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

4. **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.

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

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

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

8. **Contribution** is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion.

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

a) Cancer of Specified Severity

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & 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.

The following are excluded –

1. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
2. Any skin cancer other than invasive malignant melanoma
3. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
4. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
5. Chronic lymphocytic leukaemia less than RAI stage 3
6. Microcarcinoma of the bladder
7. All tumours in the presence of HIV infection.

b) First Heart Attack of Specified Severity

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

1. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
2. new characteristic electrocardiogram changes
3. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

1. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
2. Other acute Coronary Syndromes
3. Any type of angina pectoris.

c) Open Chest CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

Excluded are:

1. Angioplasty and/or any other intra-arterial procedures
2. Any key-hole or laser surgery.

d) Open Heart Replacement or Repair of Heart Valves

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

e) Coma of Specified Severity

1. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
2. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

f) Kidney Failure Requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, 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.

The following are excluded:

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

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

   The following are excluded:

   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

i) Permanent Paralysis of Limbs

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

j) Motor Neurone Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

1. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
3. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

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

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

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

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

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

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

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

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

15. **Covered Relationships shall include** spouse, children, brother and sister 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.

16. **Cumulative Bonus**
    Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

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

    Treatment normally taken on an out-patient basis is not included in the scope of this definition. For the list of Day Care Treatments please refer Annexure II attached to and forming part of this Policy.

18. **Day Care Centre -** A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -u p 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.

19. **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.

20. **Dependent Child** A dependent child refers to a child (natural or legally adopted), who is financially dependent on the Policy Holder, does not have his / her independent source of income, is up to the age of 23 years.

21. **Dental Treatment -** Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

22. **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.

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

b) the patient takes treatment at home on account of non-availability of room in a hospital.

24. **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.

25. **Emergency Care** means management for a severe illness or injury which results insymptoms 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.

26. **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.

27. **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.

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

29. **Hospitalisation or Hospitalised** means admission in a hospital for a minimum period of 24 in patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

30. **Illness** means sickness or disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

31. **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:-it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests- it needs on-going or long term control or relief of symptoms- it requires your rehabilitation or for you to be specially trained to cope with it-it continues indefinitely-it comes back or is likely to come back.

32. **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.

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

34. **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.

35. **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.

36. **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.

37. **Maternity Expense** shall include the following:
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);
    ii. Expenses towards lawful medical termination of pregnancy during the Policy Period

38. **Maternity Sum Insured** means the sum specified in the Schedule against the Benefit

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

40. **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 advise 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.

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

42. **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 Governement and is and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

43. **New Born Baby** means baby born during the Policy Period and is Aged between 1 day and 90 days, both days inclusive.

44. **Network Provider** means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

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

46. **Notification of Claim** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

47. **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.

48. **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.

49. **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.

50. **Policy Year** means a period of 12 consecutive months commencing from the Inception Date.

51. **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.

52. **Pre-existing Disease** is any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

53. **Pre-hospitalization Medical Expenses** are Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

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

54. **Post-hospitalization Medical Expenses**

Medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

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

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

55. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time- bound exclusions if he/she chooses to switch from one insurer to another.

56. **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.

57. **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 by comparable providers only.

58. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating renewal continuous for the purpose of all waiting periods.

59. **Restored Sum Insured** means the amount restored in accordance with Section 2.1.10 of this Policy

60. **Room Rent** - Room Rent shall mean the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

61. **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) and if more than one, then the latest in time.
62.
63. **Single Private Room** means a single Hospital room of any rating with/without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. This excludes a suite.

64. **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.
    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.

65. **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

66. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

67. **TPA** means any person who is licenses under the IRDA (Third Party Administrators – Health Services) Regulations 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

68. **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.

69. **We/Our/Us/Insurer** means CignaTTK Health Insurance Company Limited

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

Annexure – I:
Ombudsmen

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.:- 079-27546150/139 Fax:- 079-27546142 Email:- bimalokpal.ahmedabad@gbic.co.inmailto:insombahd@rediffmail.com	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Mangal Bldg., 2nd Floor, Behind Canara Mutual Bldgs., No.4, Residency Road, Bengaluru – 560 025. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Bhopal – 462 011. Tel.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@gbic.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@gbic.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:-bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court,	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).

4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@gbic.co.in	
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239633/23237539 Fax:- 011-23230858 Email:- bimalokpal.delhi@gbic.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Fax:- 0361-2732937 Email:- bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Fax: 0141 -Bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM 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@gbic.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
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	West Bengal, Bihar, Sikkim, Jharkhand and Andaman and Nicobar Islands.

Email:- bimalokpal.kolkata@gbic.co.in	
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@gbic.co.inmailto:ioblko@sancharnet.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022-26106552/6960 Fax:- 022-26106052 Email:- bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 -32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure – II:

List of Day Care Treatments/Surgeries/Procedures covered under Section 2.1.4 including but not limited to the following:

Microsurgical Operations on the middle ear

1. Stapedotomy to treat various lesions in the middle ear
2. Revision of Stapedotomy
3. Othe roperations of the auditory ossicles
4. Myringoplasty (post-aura/ endural approach as well as simple Type – I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicle)
6. Revision of a Tympanoplasty
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

8. Myringotomy
9. Removal of a tympanic drain
10. Incision of the mastoid process and middle ear

11. Mastoidectomy
12. Reconstruction of the middle ear
13. Other excisions of the middle and inner ear
14. Fenestration of the inner ear
15. Revision of a fenestration of the inner ear
16. Incision (opening) and destruction (elimination) of the inner ear
17. Other operations on the middle ear
18. Removal of Keratosis Obturans

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration
23. Foreign body removal from nose

Operations on the eyes

24. Incision of tear glands
25. Other operations on the tear ducts
26. Incision of diseased eyelids
27. Correction of Eyelids Ptosis by Levator Palpebrae Superioris Resection (bilateral)
28. Correction of Eyelids Ptosis by Fascia Lata Graft (bilateral)
29. Excision and destruction of diseased tissue of the eyelid
30. Operations on the canthus and epicanthus
31. Corrective surgery for entropion and ectropion
32. Corrective surgery for blepharoptosis
33. Removal of a foreign body from the conjunctiva
34. Removal of a foreign body from the cornea
35. Incision of the cornea
36. Operations for pterygium
37. Other operations on the cornea
38. Removal of a foreign body from the lens of the eye
39. Removal of a foreign body from the posterior chamber of the eye
40. Removal of a foreign body from the orbit and eyeball
41. Operation of cataract
42. Diathermy/ Cryotherapy to treat retinal tear
43. Anterior chamber Pancentesis/ Cyclodiathermy/ Cyclocryotherapy/ goniotomy/ Trabeculotomy and Filtering and Allied operations to treat glaucoma
44. Enucleation of the eye without implant
45. Dacryocystorhinostomy for various lesions of Lacrimal Gland
46. Laser photocoagulation to treat ratinal Tear

Operations on the skin & subcutaneous tissues

47. Incision of a pilonidal sinus
48. Other incisions of the skin and subcutaneous tissues
49. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
50. Local excision of diseased tissue of the skin and subcutaneous tissues
51. Other excisions of the skin and subcutaneous tissues
52. Simple restoration of surface continuity of the skin and subcutaneous tissues
53. Free skin transplantation, donor site
54. Free skin transplantation, recipient site
55. Revision of skin plasty
56. Other restoration and reconstruction of the skin and subcutaneous tissues
57. Chemosurgery to the skin
58. Destruction of diseased tissue in the skin and subcutaneous tissues

59. Recontruction of deformity/ defect in NailBed

Operations on the tongue

60. Incision, excision and destruction of diseased tissue of the tongue
61. Partial glossectomy
62. Glossectomy
63. Reconstruction of the tongue
64. Other operations on the tongue

Operations on the salivary glands & salivary ducts

65. Incision and lancing of a salivary gland and a salivary duct
66. Excision of diseased tissue of a salivary gland and a salivary duct
67. Resection of a salivary gland
68. Reconstruction of a salivary gland and a salivary duct
69. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

70. External incision and drainage in the region of the mouth, jaw and face
71. Incision of the hard and soft palate
72. Excision and destruction of diseased hard and soft palate
73. Incision, excision and destruction in the mouth
74. Palatoplasty
75. Other operations in the mouth

Operations on tonsils and adenoids

76. Transoral incision and drainage of pharyngeal abscess
77. Tonsillectomy without adenoidectomy
78. Tonsillectomy with adenoidectomy
79. Excision and destruction of a lingual tonsil
80. Other operations on the tonsil and adenoids
81. Traumasurgery and orthopaedics
82. Incision on bone, septic and aseptic
83. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
84. Suture and other operations on tendons and tendon sheath
85. Reduction of dislocation under GA
86. Adnoidectomy

Operations on the breast

87. Incision of the breast
88. Operations on the nipple
89. Excision of single breast lump

Operations on the digestive tract, Kidney and bladder

90. Incision and excision of tissue in the perianal region
91. Surgical treatment of anal fistulas
92. Surgical treatment of haemorrhoids
93. Division of the anal sphincter (sphincterotomy)
94. Other operations on the anus
95. Ultrasound guided aspirations
96. Sclerotherapy etc.
97. Laprotomy for grading Lymphoma with Splenectomy/ Liver/ Lymph Node Biopsy
98. Therapeutic laproscopy with Laser
99. Cholecystectomy and choledocho – jejunostomy/ Duodenostomy/ Gastrostomy/ Exploration Common Bile Duct

100. Esophagoscopy, gastroscopy, dudenoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions
101. Lithotripsy/ Nephrolithotomy for renal calculus
102. Excision of renal cyst
103. Drainage of Pyonephrosis/ Perinephric Abscess
104. Appendicectomy with/ without Drainage

Operations on the female sexual organs

105. Incision of the ovary
106. Insufflation of the Fallopian tubes
107. Other operations on the Fallopian tube
108. Dilatation of the cervical canal
109. Conisation of the uterine cervix
110. Theraputic curettage with Colposcopy/ Biopsy/ Diathermy/ Cryosurgery
111. Laser therapy of cervix for various lesions of Uterus
112. Other operations of the Uterine cervix
113. Incesion of the uterus (hysterectomy)
114. Local incision and destruction of diseased tissue of the vagina and the pouch of Douglas
115. Incision of the vagina
116. Incision of vulva
117. Culdotomy
118. Operations on Bartholin's glands (cyst)
119. Salpino-Oophorectomy via Laproscopy

Operations on the prostate & seminal vesicles

120. Incision of the prostate
121. Transurethral excision and destruction of prostate tissue
122. Transurethral and percutaneous destruction of prostate tissue
123. Open surgical excision and destruction of prostate tissue
124. Radical prostatovesiculectomy
125. Other excision and destruction of prostate tissue
126. Operations on the seminal vesicles
127. Incision and excision of periprostatic tissue
128. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

129. Incision of the scrotum and tunica vaginalis testis
130. Operation on a testicular hydrocele
131. Excision and destruction of diseased scrotal tissue
132. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

133. Incision of the testes
134. Excision and destruction of diseased tissue of the testes
135. Unilateral orchidectomy
136. Bilateral orchidectomy
137. Orchidopexy
138. Abdominal exploration in cryptorchidism
139. Surgical repositioning of an abdominal testis
140. Reconstruction of the testis
141. Implantation, exchange and removal of a testicular prosthesis
142. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

143. Surgical treatment of a varicocele and a hydrocele of the spermatic cord

144. Excision in the area of the epididymis
145. Epididymectomy

Operations on the penis

146. Operations on the foreskin
147. Local excision and destruction of diseased tissue of the penis
148. Amputation of the penis
149. Other operations on the penis

Operations on the urinary system

150. Cystoscopical removal of stones
151. Catheterisation of baldder

Other Operations

152. Lithotripsy
153. Coronary angiography
154. Biopsy of Temporal Artery for Various leisons
155. External Arterio-venus shunt
156. Haemodialysis
157. Radiotherapy for Cancer
158. Cancer Chemotherapy
159. Endoscopic polypectomy

Operation of bone and joints

160. Surgery for ligament tear
161. Surgery for meniscus tear
162. Surgery for hemoarthrosis/ pyoarthrosis
163. Removal of fracture pins/ nails
164. Removal of metal wire
165. Closed reduction on fracture, luxation
166. Reduction of dislocation under GA
167. Epiphyseolysis with osterosynthesis
168. Excision of Bursirtis
169. Tennis elbow release
170. Excision of various lesions in Coccyx
171. Arthroscopic knee aspiration

Annexure – III:

<table>
<tr><th colspan="7">CignaTTK ProHealth Insurance(Plan- Benefit Structure)</th></tr>
<tr><th></th><th>Plan</th><th>Protect</th><th>Plus</th><th>Preferred</th><th>Premier</th><th>Accumulate</th></tr>
<tr><td rowspan="3">Basic Covers</td><td>Sum Insured</td><td>₹2.5 Lac,
₹3.5 Lac,
₹4.5 Lac
₹5.5 Lac
₹7.5 Lac
₹10 Lac</td><td>₹4.5 Lac,
₹5.5 Lac,
₹7.5 Lac,
₹ 10 Lac</td><td>₹15 Lac,
₹30 Lac,
₹ 50 Lac,</td><td>₹100 Lac</td><td>₹ 5.5 Lac
₹ 7.5 Lac
₹ 10 Lac
₹ 15 Lac
₹ 20 Lac
₹ 25 Lac</td></tr>
<tr><td>In-patient Hospitalization</td><td colspan="2">Covered up to Single Private room</td><td colspan="2">Covered up to any room category except Suite</td><td>Covered up to Single Private room</td></tr>
<tr><td>Pre - Hospitalization</td><td colspan="4">Covered up to 60 days before date of hospitalisation</td><td>Covered up to 60 days before date of</td></tr>
</table>

					hospitalisation
	Post-Hospitalization	Covered up to 90 days post discharge from hospital	Covered up to 180 days post discharge from hospital		Covered up to 90 days post discharge from hospital
	Day Care Treatment	Covered up to full Sum Insured - for 171 Procedures			
	Domiciliary Treatment	Covered up to full Sum Insured			
	Pre-existing Diseases	Covered after 48 months of continuous coverage	Covered after 36 months of continuous coverage	Covered after 24 months of continuous coverage	Covered after 24 months of continuous coverage	Covered after 48 months of continuous coverage
	Ambulance Cover	Up to ₹ 2000 per hospitalization event	Up to ₹ 3000 per hospitalization event	Actual expenses paid per hospitalization event	Up to ₹ 2000 per hospitalization event
	Donor Expenses	Covered upto full Sum Insured			
	Worldwide Emergency Cover	Covered upto full Sum Insured once in a policy year			
	Restoration Of Sum Insured	Available once in a policy year for unrelated illnesses in addition to the Sum Insured opted		Not Available	Available once in a policy year for unrelated illnesses in addition to the Sum Insured opted
	Health Maintenance Benefits	Covered up to ₹ 500	Covered up to ₹ 2000	Covered up to ₹ 15000 per policy year	Option to choose from - ₹ 5000, ₹ 10000, ₹ 15000, ₹ 20000
	Maternity Expenses	Not Available	Covered upto ₹ 15,000 for normal delivery and ₹ 25,000 for C-Section per event after a waiting period of 48 months	Covered upto ₹ 50,000 for normal delivery and ₹ 100,000 for C-Section per event after a waiting Period of 48 months	Not Available
	New Born Baby Expenses	Not Available	Covered upto Limit under Maternity Expenses		Not Available
	First Year Vaccinations	Not Available	Covered as per national immunization programme over and above Maternity Expenses		Not Available

Value Added Covers	**Health Check-Up**	Available once every 3rd Policy year to all insured persons who have completed 18 years of Age	Available at each policy year(excl the first year), to all insured persons who have completed 18 years of Age		Available once every 3rd Policy year to all insured persons who have completed 18 years of Age
	Expert Opinion on Critical illness	Available once during the Policy Year			
	Cumulative Bonus	5% Increase in Sum Insured, maximum upto 100%	10% Increase in Sum Insured, maximum upto 100%	Not Available	5% Increase in Sum Insured, maximum upto 100%
	Healthy Rewards	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used to get a discount in premium from the 2nd Annual Premium OR they can be redeemed for equivalent value of Health Maintenance Benefits any time during the policy OR as equivalent value while availing services through our Network Providers as defined in the policy.			
Optional Covers	**Deductible***	₹ 1/₹ 2 /₹ 3 Lacs		Not Available	50k, ₹ 1Lac, ₹2 Lac, ₹3 Lac, ₹4 Lac, ₹5 Lac
	Reduction in Maternity Waiting	Not Available	Maternity waiting period Reduced to 24 months		Not Available
	Voluntary Co-Payment* *Voluntary Co-pay and Deductible cannot be taken under a single plan	10% or 20% voluntary co-payment for each and every claim as opted on the Policy		Not Available	10% or 20% voluntary co-payment for each and every claim as opted on the Policy
	Waiver of Mandatory Co-payment	Option to remove a mandatory Co-pay for Insured Persons aged 65 years and above			
	Cumulative Bonus Booster	Optional cover 25% Increase in Sum Insured, maximum upto 100%.		Not Available	Optional cover 25% Increase in Sum Insured, maximum upto 100%.
Riders	**Add On cover Critical Illness**	Lump sum payment of 100% of opted Sum Insured		Not Available	Lump sum payment of 100% of opted Sum Insured

Annexure IV

List of Non-Medical Expenses

SNO	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy	SUGGESTIONS
TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable

37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFIC ALL Y EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified

71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and STORAGE	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	ANTISEPTIC or DISINFECTANT LOTIONS	Not Payable -Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable -Part of Dressing Charges
88	COTTON	Not Payable -Part of Dressing Charges
89	COTTON BANDAGE	Not Payable -Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits

97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge , Not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES		
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTENANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable

132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not Payable
135	INFUSION PUMP - COST	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Device not Payable
137	PULSEOXYMETER CHARGES	Device not Payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not Payable
140	SP 02 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadripiegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential an d should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.

ITEMS PA YABLE IF SUPPORTED BY A PRESCRIPTION

156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\ DSINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed

162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT o r ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164	HIV KIT	Payable - payable Pre-operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable

PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE

173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost

OTHERS

176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVID requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports an d Charts required / Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable

194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	P ayable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs an d then 1 in 24 hrs
197	URINE BAG	Payable w here medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.