Manipal Cigna
Health Insurance

EVERY DETAIL MATTERS TO YOUR HEALTH.

FIND THEM LISTED IN YOUR POLICY TERMS & CONDITIONS

ManipalCigna ProHealth Insurance
Customer Information Sheet

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief						Refer to the following Policy Section number in the Policy Wording for more details on each cover
Your Coverage Details:	**Identify your Plan**	**Protect**	**Plus**	**Preferred**	**Premier**	**Accumulate**	
Basic Cover: This section lists the Basic benefits available on your plan	Identify your Opted Sum Insured (SI)	₹ 2.5 Lacs ₹ 3.5 Lacs ₹ 4.5 Lacs, ₹ 5.5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	₹ 4.5 Lacs ₹ 5.5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	₹ 15 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	₹ 100 Lacs	₹ 5.5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	
	Inpatient Hospitalisation (When you are hospitalised)	For Sum Insured up to ₹ 5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹ 7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category	Covered upto any Room Category except Suite or higher category			For Sum Insured ₹ 5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹ 7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category	II.1
	Pre - hospitalisation	Medical Expenses Covered up to 60 days before date of hospitalisation					II.2
	Post - hospitalisation	Medical Expenses Covered up to 90 days post discharge from hospital	Medical Expenses Covered up to 180 days post discharge from hospital			Covered up to 90 days post discharge from hospital	II.3
	Day Care Treatment	Covered up to the limit of Sum Insured opted					II.4
	Domiciliary Treatment (Treatment at Home)	Covered up to the limit of Sum Insured opted					II.5
	Ambulance Cover (Reimbursement of Ambulance Expenses)	Upto ₹ 2000 paid per hospitalisation event	Upto ₹ 3000 paid per hospitalisation event	Actual incurred expenses paid per hospitalisation event		Upto ₹ 2000 paid per hospitalisation event	II.6
	Donor Expenses (Hospitalisation Expenses of the donor providing the organ)	Covered up to full Sum Insured					II.7
	Worldwide Emergency Cover (Outside India)	Covered up to full Sum Insured once in a Policy Year					II.8
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for unrelated illnesses in addition to the Sum Insured opted					II.9

	AYUSH Cover	Covered up to full Sum Insured				II.10
	Health Maintenance Benefit (Treatment that does not require hospitalisation and can be carried out in an Out Patient Department)	Covered up to ₹ 500 per policy year	Covered up to ₹ 2000 per policy year	Covered up to ₹ 15,000 per policy year.	Option to choose from - ₹ 5000, ₹ 10,000, ₹ 15,000, ₹ 20,000 per policy year Can also be used to pay for Co-pay or Deductible. Up to 50 % of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy	II.11
	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	Covered upto ₹ 100,000 for normal delivery and ₹ 200,000 for C-Section per event, after a waiting Period of 48 months	Not Available	II.12
	New Born Baby Expenses		Covered for the inpatient hospitalisation expenses of a new born up to the limit provided under Maternity Expenses				II.13
	First Year Vaccinations		Covered as per national immunisation programme over and above Maternity Sum Insured				II.14
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Health Check-up	Available once every 3rd Policy year to all insured persons who have completed 18 years of Age	Available each policy year(excluding 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	III.1
	Expert Opinion on Critical illness (By a Specialist)	Available once during the Policy Year				III.2
	Cumulative Bonus	A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.	A guaranteed 10% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.		A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.	III.3
	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 against payable premium (including Taxes) from 1st Renewal of the Policy. 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.				III.4

Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Hospital Daily Cash Benefit	₹ 1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹ 2000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹ 3000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹ 1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	IV.1
	Deductible (Please select the Sum Insured and Deductible amount as you have opted on the Policy. Deductible is the amount beyond which a claim will be payable in the Policy)	₹ 1/ 2/ 3/ 4/ 5/ 7.5 /10 Lacs		Not Available	₹ 0.5/ 1/ 2/ 3/ 4/ 5/ 7.5 / 10 Lacs	IV.2
	Waiver of Deductible	Available		Not available	Available	IV.2
	Reduction in Maternity Waiting	Not available	Maternity waiting period Reduced from 48 months to 24 months		Not available	IV.3
	Voluntary Co-pay (The cost sharing percentage that you have opted will apply on each claim.) If you have opted for a Deductible, Voluntary Co-payment does not apply	10% or 20% Voluntary Co-payment for each and every claim as opted		Not Available	10% or 20% voluntary co-payment for each and every claim as opted on the Policy	IV.4
	Waiver of Mandatory Co-pay	Waiver of Mandatory co-payment of 20% for Insured Persons aged 65 years and above				IV.5
	Cumulative Bonus booster	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured		Not Available	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured	IV.6
Add on cover(Rider) This section lists the Add on cover available under your plan	Critical Illness	Lump sum payment of an additional 100% of Sum Insured Opted		Not Available	Lump sum payment of an additional 100% of Sum Insured Opted	Add on policy wordings

What are the Major exclusions in the Policy This section provides a brief list of the major charges/ treatments which will not be covered under the Policy permanently.	Please note that this is an indicative list of exclusions; please refer the Policy wording and clauses for the complete list of exclusions. - Investigation & Evaluation- Code- Excl. 04 - Rest Cure, rehabilitation and respite care- Code- Excl. 05 - Obesity/ Weight Control: Code- Excl. 06 - Change-of-Gender treatments: Code- Excl. 07 - Cosmetic or plastic Surgery: Code- Excl. 08 - Hazardous or Adventure sports: Code- Excl. 09 - Breach of law: Code- Excl. 10 - Excluded Providers: Code- Excl. 11 - Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof Code- Excl. 12 - Treatments received in heath hydros, nature cure clinics, spas or similar establishments s. Code- Excl. 13 - Dietary supplements and substances that can be purchased without prescription. Code- Excl. 14 - Refractive Error: Code- Excl. 15 - Unproven Treatments: Code- Excl. 16 - Sterility and Infertility: Code- Excl. 17 - Maternity: Code Excl. 18 (applicable to Protect and Accumulate plan) - External Congenital Anomaly or defects. - Dental treatment. - Circumcision - Prostheses, corrective devices and/or medical appliances - Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses. - All Illness/expenses caused by ionizing radiation or contamination by radioactivity. - All expenses caused by or arising from war or war-like situation. - Annexure III, list of “Items for which Coverage is not available in the Policy”. - Any form of Non-Allopathic treatment (except AYUSH In-patient Treatment), - 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. - Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body. *Note: This list does not apply to coverage under Health Maintenance Benefit	VI
Waiting Period This sections lists the applicable period (days/ months) before you can make a claim for the listed diseases/ treatments	a. First 30 days from the Policy start date, for all illnesses except accidents. 90 days waiting period will be applicable for listed Critical Illness where Critical Illness Add on cover has been opted. b. Specified disease/procedure waiting period: Two Year Waiting Period will be applicable for specific illnesses c. A 48 months of waiting period will be applicable for Maternity, New Born and First year Vaccination expenses (Except where Reduction in Maternity Waiting is opted) d. A Personal waiting period may apply to individuals depending upon declarations on the proposal form and existing health conditions. Please refer to the “Special Conditions” Column on your Policy Schedule to identify if any personal waiting period is applied to your Policy. e. Pre-existing disease waiting period: A 48 months waiting period will be applicable for any Pre-existing disease, for Protect, a 36 months waiting period for any Pre-existing disease, for Plus and Accumulate plan and 24 months waiting period for Preferred & Premier Plan.	V.2 Add on policy wordings V.3 V.4 V.5 V.1
Pay-out Basis This section lists the manner in which the proceeds of the Policy will be paid to you	a. For all covers (excluding Critical Illness Add On Benefit and Hospital Daily Cash Benefit) pay-out will be on reimbursement of actual expenses either by way of Cashless to the Hospital/ Network provider when a cashless facility is availed or directly to you as a reimbursement against the bills when you have paid for the expenses. b. Critical Illness Add on pay-out will be on benefit payment basis as a lump sum fixed amount. c. Health Maintenance Benefit will be on reimbursement basis on submission of bills or payment towards Deductible or Co pay wherever opted.	VII Add on policy wordings VII.13

Cost Sharing This sections lists the various circumstances under which you will bear some portion of the claim out of your pocket	a. A mandatory co-payment will be applicable for insured's aged 65 years and above b. A Voluntary co-payment of 10% or 20% on admissible claim amount (final payable claim amount after assessment) will apply to each and every claim if opted under the plan. c. A deductible option of ₹ 1 Lac, ₹ 2 Lacs, ₹ 3 Lacs, ₹ 4 Lacs, ₹ 5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs as per plan selected will apply on the Policy if opted. All payable claims up to this amount will be borne by you. Any claim over and above this limit will become payable under the Policy. To know the applicable deductible on your Policy please refer the Policy Schedule benefits. Co-pays under "b" above will not be applied for a Deductible Cover. Persons opting to take treatment outside of their Zone will bear a 10% or 20% co-pay as applicable. d. A deductible of ₹ 50,000, ₹ 1Lac, ₹ 2 Lacs, ₹ 3 Lacs, ₹ 4 Lacs, ₹ 5 Lacs, ₹ 7.5 Lacs,₹ 10 Lacs as opted will apply on Accumulate Plan. All payable claims up to this amount will be borne by you. Any claim over and above this limit will become payable under the Policy. To know the applicable deductible on your Policy please refer the Policy Schedule benefits. e. If a special sub-limit is applied at the time of Underwriting on a particular medical condition, the Policy will pay only 75% of the payable claim amount arising out of the specified illness/medical condition.	VIII.9 IV.4 VII.17 VII.17 VIII.18
Renewal Conditions This section lists the terms of renewals under the Policy	a. This Policy is ordinarily renewable for lifetime on mutual consent, subject to application of Renewal and realisation of Renewal premium. b. Continuity will be provided if renewed within 30 days from the date of expiry of previous policy. If there is a break in the policy, any claim occurring within the break in period will not be covered under the Policy. c. Renewals will not be denied except on grounds of misrepresentation, fraud, non-disclosure or non-co-operation from the Insured. d. Alterations in the policy such as 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. We reserve Our right to carry out underwriting in relation to any request for changes on the Policy. The terms and conditions of existing policy will not be altered.	VIII.16
Renewal Benefits This section lists the various benefits you can avail/ accumulate every time you renew a Policy with us	a. Cumulative Bonus- We will provide a 5% or 10% or 25% increase in Sum Insured for every policy year, subject to a maximum of 200% accumulation, as per the Plan opted. The cumulative bonus will remain intact and not get reduced in case a claim is made during the policy. b. Health check-up – A health check-up is provided for persons aged 18 years and above, irrespective of the claim status of the Policy. For Protect & Accumulate plan – Available once every 3rd Policy year For Plus, Preferred and Premier Plan – Available once at each policy year (excluding first year) c. Healthy Rewards – Reward Points are earned for each year of premium paid	III.3 III.1 III.4
Cancellation The section explains the Policy cancellation process in brief	a. Cancellations may be intimated to Us by giving 15 days' notice wherein We shall refund the premium for the unexpired term on the short period scale as mentioned in the Policy wordings enclosed in the kit. The Premium shall only be refunded only if no claim has been made under the Policy. This Policy can be cancelled on grounds of misrepresentation, fraud, non-disclosure of material fact, upon giving 15 days' notice without refund of premium. Cover may end immediately for all Insured Persons, if there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing.	VIII.14

Legal disclaimer: ***The information mentioned above is illustrative and not exhaustive. Information must be read in conjunction with the product brochures and Policy document. In case of any conflict between the Prospectus and the Policy document the terms and conditions mentioned in the Policy document shall prevail.***

MANIPALCIGNA 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). All limits mentioned in the Policy Schedule are applicable for each Policy Year of coverage.

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 provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Year. 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.

Room category coverage for Sum Insured under each plan will be up to limit specified in the Policy Schedule.

If the Insured Person is admitted in a room category that is higher than the one that is specified in the 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.

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

The following procedures will be covered (wherever medically indicated) either as inpatient or as part of day care treatment in a hospital up to the Sum Insured specified in the policy schedule, during the policy period:

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy - Monoclonal Antibody to be given as injection

f. Intra vitreal injections

g. Robotic surgeries

h. Stereotactic radio surgeries

i. Bronchical Thermoplasty

j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

k. IONM - (Intra Operative Neuro Monitoring)

l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

Medical Expenses incurred towards Medically Necessary Treatment of the Insured Person for In-patient Hospitalization due to a condition caused by or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, sexually transmitted diseases (STD), in respect of an Insured Person, will be covered up to the Sum Insured in a Policy Year. The necessity of the Hospitalisation is to be certified by an authorised Medical Practitioner.

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 that occurs during the Policy Year 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 that occurs during the Policy Year 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 Section 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 otherwise have been covered for Hospitalisation under the policy but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a Hospital transfer; or

ii. A Hospital bed was unavailable;

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

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

b. 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 covered under the Policy 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 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 incurred during the Policy Year, for Emergency Treatments 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. 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.21 does not apply to this benefit.

All Claims under this benefit can be made as per the process defined under Section VII 5 & 16.

II.9. Restoration of Sum Insured:

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

a. The Sum Insured inclusive of earned Cumulative Bonus (if any) 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.12, Maternity Expenses, New Born Baby Expenses Section II.13 and First Year Vaccinations Section II.14.

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

e. Such restoration of Sum Insured will be available for any number of times, during a Policy Year to each insured in case of an individual Policy and can be 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. AYUSH Cover

We will pay the Medical Expenses incurred during the Policy Year, up to the limits specified in the Policy Schedule of an Insured Person in case of Medically Necessary Treatment taken during In-patient Hospitalisation for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year,

provided that:

The Insured Person has undergone treatment in an AYUSH Hospital where AYUSH Hospital is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:

i) Central or State Government AYUSH Hospital; or

ii) Teaching hospitals attached to AYUSH College recognized by Central Government / Central Council of Indian Medicine and Central Council of Homeopathy; or

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

a) Having at least five in-patient beds;

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

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

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

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

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

All claims under this Benefit can be made as per the process defined under Sections VII 4 & 5.

II.11. Health Maintenance Benefit:

We will cover, up to limits specific in the Schedule, by way of reimbursement of the Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred during the Policy Year on:

i. an Out Patient basis for Protect, Plus, Preferred and Premier Plans

ii. an Out Patient and In-patient basis for Accumulate Plan.

Coverage and validity for HMB under Protect, Plus, Preferred, Premier and Accumulate will be as per below table:

Plan Name	Coverage	Validity
Protect, Plus, Preferred & Premier	i. Diagnostic tests, preventive tests, drugs, prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule. ii. Towards Dental Treatments and AYUSH Forms of Medicines wherever prescribed by a Medical Practitioner.	i. Fresh limits will be available as per the Plan under the new Policy Year ii. Any unutilised Health Maintenance Benefit limit shall lapse at the end of the Policy Year
Accumulate	i. Diagnostic tests, preventive tests, drugs, Non- Medical expenses as defined under Annexure IV of the policy), prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), crutches and wheel chair prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule. ii. Towards Dental Treatments and AYUSH Forms of Medicines wherever prescribed by a Medical Practitioner as an Out-Patient. iii. Towards payment of the deductible/ co-pay/ Non-Medical expenses (as defined under Annexure IV of the policy), of a claim wherever opted and applicable including any cashless facility in case of a Hospitalization or Day Care Claim. iv. Towards payment of renewal premium (inclusive of taxes): Up to 50 % of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy. Subject to renewal of the policy in Accumulate Plan.	i. Fresh limits will be available as per the Plan under the new Policy Year ii. Any unutilised Health Maintenance Benefit limit shall not lapse at the end of the Policy Year and 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. iii. In case of expiry of the policy any unutilized Health Maintenance Benefit limit shall be available for a claim up to a period of 12 months from the date of expiry of the Policy. iv. In case of utilisation of Health Maintenance Benefit post expiry of the policy year, the cumulative bonus shall be suitably adjusted basis revised Health Maintenance Benefit balance for the previous policy year.

Insured can use Our application or contact Us for scheduling an appointment for availing services covered under this benefit at our Network provider.

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.

All Claims under this benefit can be made as per the process defined under Section VII.13. Further, all claims under this benefit will be subject to the any one claim limits specified under Section VII.15 of the Policy.

II.12. 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 incurred during the Policy Year, 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.

(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.13. New Born Baby Expenses:

Subject to a claim being admitted under Maternity Expenses Cover under Section II.12, 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.

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

II.14. 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 VIII. 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 arranged by Us and conducted at Our Network Providers.

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.

Sum Insured	Age	List of tests
Protect Plus & Accumulate Plan Sum Insured ₹2.5 Lacs, ₹3.5 Lacs, ₹4.5 Lacs, ₹5.5 Lacs	>18 years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT
Protect Plus & Accumulate Plan Sum Insured ₹7.5 Lacs, ₹10 Lacs	18 to 40 years	Vitals, ECG, FBS, Sr. Creatinine,, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
	> 40 years (For Females Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH
	> 40 years (For Males Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
Protect Plus & Accumulate Plan Sum Insured ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹50 Lacs, ₹100 Lacs	18 to 40 years (For Females Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH
	18 to 40 years (For Males Only)	Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
	> 40 years (For Females Only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT
	> 40 years (For Males Only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT
Preferred & Premier Plan Sum Insured ₹15 Lacs and Above	18 to 40 years (For Females Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, Pap smear, Mammogram
	18 to 40 years (For Males Only)	Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, PSA
	> 40 years (For Females Only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, Pap smear, Mammogram, Uric acid, USG Abdomen & Pelvis
	> 40 years (For Males Only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT, PSA, Uric acid, USG Abdomen & Pelvis

Full explanation of Tests is provided here: Vitals- Height, Weight, Blood Pressure, Pulse, BMI, Chest Circumference & Abdominal Girth FBS – Fasting Blood Sugar, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT – Test Serum Glutamic Pyruvate Transaminase, SGOT – Serum Glutamic Oxaloacetic Transaminase, TSH – Thyroid Stimulating Hormone, TMT – Tread Mill Test, 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. 15

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 Year. The expert opinion would be directly sent to the Insured Person.

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

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

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

(c) This benefit 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 –

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. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded -

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

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

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

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

ii. new characteristic electrocardiogram changes

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

II The following are excluded:

1. Other acute Coronary Syndromes

2. Any type of angina pectoris.

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

c) Open Chest CABG

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

II The following are excluded:

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

d) Open Heart Replacement or Repair of 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.

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

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:

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

b) The Cumulative Bonus will not be accumulated in excess of 200% of the Sum Insured under the current Policy with Us under any circumstances.

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

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

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

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

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

h) Cumulative bonus shall not be available for claims made for maternity expenses, new born baby cover, first year vaccination.

i) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section VIII.12

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.
- 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 plus Cumulative 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 for Accumulate plan 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.

In an individual or floater policy: There will be no limitation to the number of programs one can enrol however Rewards can be earned only once for each specific program by a particular Insured Person in a policy year.

Maximum rewards that can be earned in a single policy period will be limited to 20% 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)/ Targeted Risk Assessment (TRA)	2.5%
Lifestyle Management Program (LMP)	3%
Chronic Condition Management Programs	3%
Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives	2% per program, Maximum 5 programs per policy year
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 –

- Against payable premium (including Taxes) 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.

Details of Healthy Rewards earned on each Policy will be updated in our records against the policy as and when earned. Accrual for reward points will be the same for 1, 2 & 3 year policies.

Policyholder/Insured can approach Us for redemption anytime during the policy period. Redemption against renewal premium will be available only at the time such renewal is due.

Any earned reward points will lapse at the end of the grace period if the policy is not renewed with us.Refer Annexure for Healthy Reward Process for details of delivery mechanism.

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. Hospital Daily Cash Benefit

We will pay the Hospital Daily Cash Benefit specified in the Policy for each continuous and completed 24 Hours of Hospitalisation during the Policy Year, provided that:

i. The hospitalisation claim is admissible under the Base cover.

ii. The Benefit will be available up to the maximum 30 days per Policy Year.

iii. The Benefit under this cover will be over and above the Sum Insured under Section II.

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

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

IV.2.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. Deductible shall apply to all sections other than Hospital Daily Cash Benefit, Health Maintenance Benefit, Health Check Up benefits and Add On Riders if opted.

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.17 of Claims Process.

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

Waiver of Deductible:

We will offer the Insured Person an option to opt out of the Deductible Option under the product at the time of renewal under below conditions:

- Opt out of deductible Within 48 Months

- The enhanced coverage during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods or earlier. All waiting periods as mentioned under the policy shall apply afresh for this enhanced limit from the effective date of such enhancement.
- Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of the insured member at renewal.

- Opt out of deductible After 48 Months:

- The enhanced coverage will be available for any illness, disease, injury already contracted under the preceding Policy Periods or earlier with continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy, provided that it has been renewed with Us continuously and without any interruption.
- Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of insured member at renewal.

IV.3. Reduction in Maternity Waiting:

We will provide for a waiver of waiting period for Maternity Expenses (Section II.12) 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.12) shall apply.

IV.4. 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 apply to all sections other than Health Maintenance Benefit, Health Check-Ups, Hospital Daily Cash Benefit 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 V.4), and/or if You chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction.

IV.5 Waiver of Mandatory Co-pay:

We will provide 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.6. Cumulative Bonus Booster:

We will provide an option to increase the Sum Insured by 25%, for each policy year up to a maximum of 200% of Sum Insured 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 200% 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.
- 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.12, New Born Baby Expenses Section II.13 and First Year Vaccinations Section II.14

V. WAITING PERIODS

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

V.1. Pre-existing Disease - Code- Excl. 01

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of applicable months (24 months for Preferred, Premier plan/ 36 months for Plus, Accumulate plan/ 48 months for Protect plan) of continuous coverage after the date of inception of the first policy with us.

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

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

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

V.2. 30 days Waiting Period - Code- Excl. 03

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

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

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

V.3. Specified disease/procedure Waiting Period - Code- Excl. 02:

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

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

to the extent of sum insured increase.

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

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

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

f. List of specific diseases/procedures:

i. Cataract,

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

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

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

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.16.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.

V.6. 90 day waiting period for Critical Illness Add On Cover (if opted):
Any critical illness contracted and/or the disease incepts or manifests during the first 90 days from the Inception Date of the policy will not be covered under the critical illness benefit wherever opted.

VI. PERMANENT EXCLUSIONS

We shall not be liable to make any payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless otherwise covered or specified under the Policy or any Cover opted under the Policy.

1. Investigation & Evaluation- Code- Excl 04

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

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

2. Rest Cure, rehabilitation and respite care- Code- Excl 05

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

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

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

3. Obesity/ Weight Control: Code- Excl 06

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

1. Surgery to be conducted is upon the advice of the Doctor

2. The surgery/Procedure conducted should be supported by clinical protocols

3. The member has to be 18 years of age or older and

4. Body Mass Index (BMI);

a. greater than or equal to 40 or

b. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: Code- Excl 07

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

5. Cosmetic or Plastic Surgery: Code- Excl 08

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

6. Hazardous or Adventure sports: Code- Excl 09

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

7. Breach of law: Code- Excl 10

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

8. Excluded Providers: Code- Excl 11

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

9. Treatment for Alcoholism, drug or substance abuse or any addictive

condition and consequences thereof. **Code- Excl 12**

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

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

12. **Refractive Error: Code- Excl 15**

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

13. **Unproven Treatments: Code- Excl 16**

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

14. **Sterility and Infertility: Code- Excl 17**

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. **Maternity: Code Excl 18** (applicable to Protect and Accumulate plan)

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;

ii. Expense towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

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

18. 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.

19. External Congenital Anomaly or defects or any complications or conditions arising therefrom.

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

21. 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.

22. Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses.

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

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

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

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

27. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment.

For complete list of Non-medical expenses, please refer to the Annexure IV List – I "Items for which Coverage is not available in the Policy"

28. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.

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

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

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

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

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 center.

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.manipalcigna.com

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

e. In case a reimbursement claim is received when a Pre-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 on pro rata basis. Such apportioned amount will apply to all “Associated Medical Expenses”. [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)

ii. Any Voluntary, Mandatory or Zonal Co-payment shall be applicable on the amount payable after applying the Section VII.7 a (i)

b) For Plans with Deductible Option

i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned on pro rata basis. Such apportioned amount will apply to all “Associated Medical Expenses”. [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)]

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

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

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 Co-pays (if applicable)

iii) Zonal Co-pays (if applicable)

iv) Sum Insured

v) Cumulative Bonus

vi) Restored Sum Insured

Claim Assessment for Benefit Plans:

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

VII.8. Claims Investigation

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

VII.9. Pre and Post-hospitalization claims

You should submit the Post-hospitalization claim documents at Your own expense within 15 days of completion of Post-hospitalization treatment or eligible post 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.10. Claim Settlement (provision for Penal Interest)

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

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

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

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

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

VII.11 Representation against Rejection:

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

VII.12. Payment Terms

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

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

For Cashless Claims, the payment shall be made to the Network Hospital 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.13. 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.14. 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.15. 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.

VII.16. 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.17. 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.17. 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.

VII.18. Application of Multiple policies clause

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

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

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

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

b) Retail policy & group policy from the Company:

i). Cashless process: In case the insured needs to utilize cashless facility for hospitalisation then the insured / hospital will intimate the Company about the hospitalisation through pre-authorisation process. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

Post discharge hospital will send as many separate claims as no. of policies with the Company with attached authorisation letters & original documents with the 1st claim & copy of documents with the other claims for settlement to the Company. The Company will settle all the claims as per policy terms & conditions & authorisation letter issued.

ii). Reimbursement Claim process: In case the Insured gets admitted & pays the entire bill & then files for reimbursement claim then he will have to intimate the Company of the admission 48 hours before admission for planned admissions & within 24 hours post hospitalisation for emergency hospitalisation along with all the policy numbers.

Post discharge insured will send all original documents & bills along with duly filled claim form. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

VIII. GENERAL TERMS AND CONDITIONS

1. Disclosure of Information

The Policy shall be null and void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. ("Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Material Change

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

3. Condition Precedent to Admission of Liability

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

4. Alterations in the Policy

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

5. 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.

6. 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.

7. 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.

8. 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.4), and/or if he chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction.

9. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases, the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

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

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

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

10. Records to be maintained

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

11. Free Look period

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

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

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

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

12. Cancellation

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

	Refund Grid as a % of Premium		
In force Period-Up to	**1 Year**	**2 Years**	**3 Years**
0 - 30 Days	75.00%	85.00%	90.00%
31 - 90 Days	50.00%	75.00%	85.00%
91 - 180 Days	25.00%	60.00%	75.00%
181 - 365 Days	NIL	50.00%	60.00%
366 - 455 Days		30.00%	50.00%
456 - 545 Days		20.00%	35.00%
546 - 730 Days		NIL	30.00%
731 - 910 Days			15.00%
More than 910 Days			NIL

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

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

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.

13. Migration

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

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

14. 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.

15. I. Renewal of Policy

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

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

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

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

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

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

II. Renewal Terms

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

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

c. 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.(xi). 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.

d. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by You.

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

f. 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.

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

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

i. 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.

j. 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.

k. 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.

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

m. 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.

n. 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.

16. 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, Gujarat and Delhi & NCR

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

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

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

(a) Persons paying Zone I premium can avail treatment all over India without any 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.

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

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.

B. Discounts under the Policy

You can avail of the following discounts on the premium on Your policy.

a. Family Discount - of 25% % for Protect and Plus Plan and 10% for Preferred, Premier and Accumulate Plans covering 2 and more family members under the same policy under the individual policy option.

b. Long Term policy discount - of a long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy.

c. Worksite Marketing Discount – A discount of 10% will be available on polices which are sourced through worksite marketing channel.

d. Voluntary Co-pay Discount – A discount of 7.5% for opting 10% Co-pay and a discount of 15% for opting a 20% Co-pay on the Policy in case of

Protect & Plus Plan.

A discount of 5% for opting 10% Co-pay and 10% for opting 20% Co-pay on the Policy in case of Accumulate Plan.

Discount under v (a) is applicable only to individual policies. All discounts under v (b) to (d) are available to both individual as well as floater policies. Maximum discount applicable on a single policy shall not exceed 40%, excluding discount for Voluntary Co-pay which is a cost sharing mechanism.

Family Discount, Long Term Discount and Worksite Marketing Discount is applied on the total Policy premium which is sum total of individual premium for Family policies.

17. 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 (a maximum of 48 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy. 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 or through an electronic mode, as the case may be and You would need to revert with consent and additional premium (if any), within the duration specified in the counter offer letter.

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

18. 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.

19. Electronic Transactions

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

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

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

20. Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

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

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

c) any other act fitted to deceive; and

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

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

21. 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.

22. Portability

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

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

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.

23. Moratorium Period

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

24. Terms and conditions of the Policy

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

25. Complete Discharge

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

26. Dispute Resolution

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

27. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement

under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

28. Withdrawal of Policy

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

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

29. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

30. Redressal of Grievance

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

Our website: www.manipalcigna.com

Email: customercare@manipalcigna.com

Toll Free : 1800-102-4462

Contact No.: + 91 22 61703600

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

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

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

For updated details of grievance officer,

kindly refer link https://www.manipalcigna.com/grievance-redressal

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

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

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

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. **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.

4. **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.

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

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

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

7. **AYUSH Hospital** An AYUSH Hospital is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:

   i) Central or State Government AYUSH Hospital; or

   ii) Teaching hospitals attached to AYUSH College recognized by Central Government / Central Council of Indian Medicine and Central Council of Homeopathy; or

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

   a) Having at least five in-patient beds;

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

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

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

8. AYUSH treatment refers to the medical and /or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems.

9. **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.

10. **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. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

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

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

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

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

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

xv. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

xviii. All tumors in the presence of HIV infection.

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

I The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood

supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

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

v. new characteristic electrocardiogram changes

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

II The following are excluded:

4. Other acute Coronary Syndromes

5. Any type of angina pectoris.

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

c) Open Chest CABG

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

II The following are excluded:

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

d) Open Heart Replacement or Repair of 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

3. 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:

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

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

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

4. 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:

4. Transient ischemic attacks (TIA)

5. Traumatic injury of the brain

6. 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:

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

4. 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:

iii. Other stem-cell transplants

iv. 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:

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

5. 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

6. 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.

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

12. **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.

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

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

15. **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

16. **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.

17. **Cumulative Bonus**

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

18. **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. 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 enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured 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** Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

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

48. **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.

49. **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.

50. **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.

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

52. **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.

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

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

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

54. **Pre-hospitalization Medical Expenses**

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

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
- The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

55. **Post-hospitalization Medical Expenses**

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

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

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

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

57. **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.

58. **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.

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

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

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

62. **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).

63. **Single Private Room** means a single Hospital room with any rating and of most economical category available at the time of hospitalisation 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 or higher category.

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

67. **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.

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

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

Annexure – I:

Ombudsman

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:- bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:-bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@ecoi.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239633/23237539 Email:- bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Email:- bimalokpal.guwahati@ecoi.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@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Email:- Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759/9338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email:- bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, and Andaman and Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330/1 Fax:- 0522-2231310 Email:- bimalokpal.lucknow@ecoi.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@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure – II:

List of Day Care Treatments/Surgeries/Procedures covered under Section II.4:

Microsurgical Operations on the middle ear

1. Stapedotomy to treat various lesions in the middle ear
2. Revision of Stapedotomy
3. Other operations 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
120. Hysteroscopic removal of myoma
121. D&C
122. Hysteroscopic resection of septum
123. Thermal cauterisation of cervix
124. Mirena insertion
125. Hysteroscopic adhesiolysis
126. LEEP (loop electrosurgical excision procedure)
127. Cryocauterisation of cervix
128. Polypectomy endometrium
129. Hysteroscopic resection of fibroid
130. LLETZ (large loop excision of transformation zone)
131. Conization
132. Polypectomy cervix
133. Hysteroscopic resection of endometrial polyp
134. Vulval wart excision
135. Laparoscopic paraovarian CYST excision
136. Uterine artery embolization
137. Laparoscopic cystectomy
138. Hymenectomy (imperforate hymen)
139. Endometrial ablation
140. Vaginal wall cyst excision
141. Vulval cyst excision
142. Laparoscopic paratubal CYST excision
143. Repair of vagina (vaginal atresia)
144. Hysteroscopy, removal of myoma
145. Ureterocoele repair – congenital internal
146. TURBT
147. Vaginal mesh for POP
148. Laparoscopic myomectomy
149. Surgery for SUI
150. Repair recto- vagina fistula
151. Pelvic floor repair (excluding fistula repair)
152. URS + ll
153. Laparoscopic oophorectomy
154. Normal vaginal delivery & variants

Operations on the prostate & seminal vesicles

155. Incision of the prostate
156. Transurethral excision and destruction of prostate tissue
157. Transurethral and percutaneous destruction of prostate tissue
158. Open surgical excision and destruction of prostate tissue
159. Radical prostatovesiculectomy
160. Other excision and destruction of prostate tissue
161. Operations on the seminal vesicles
162. Incision and excision of periprostatic tissue
163. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

164. Incision of the scrotum and tunica vaginalis testis
165. Operation on a testicular hydrocele
166. Excision and destruction of diseased scrotal tissue
167. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

168. Incision of the testes
169. Excision and destruction of diseased tissue of the testes
170. Unilateral orchidectomy
171. Bilateral orchidectomy
172. Orchidopexy
173. Abdominal exploration in cryptorchidism
174. Surgical repositioning of an abdominal testis
175. Reconstruction of the testis
176. Implantation, exchange and removal of a testicular prosthesis
177. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

178. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
179. Excision in the area of the epididymis
180. Epididymectomy

Operations on the penis

181. Operations on the foreskin
182. Local excision and destruction of diseased tissue of the penis
183. Amputation of the penis
184. Other operations on the penis

Operations on the urinary system

185. Cystoscopical removal of stones
186. Catheterisation of baldder

Other Operations

187. Lithotripsy
188. Coronary angiography
189. Biopsy of Temporal Artery for Various leisons
190. External Arterio-venus shunt
191. Haemodialysis
192. Radiotherapy for Cancer
193. Cancer Chemotherapy
194. Endoscopic polypectomy

Operation of bone and joints

195. Surgery for ligament tear
196. Surgery for meniscus tear
197. Surgery for hemoarthrosis/ pyoarthrosis
198. Removal of fracture pins/ nails
199. Removal of metal wire
200. Closed reduction on fracture, luxation
201. Reduction of dislocation under GA
202. Epiphyseolysis with osterosynthesis
203. Excision of Bursirtis
204. Tennis elbow release
205. Excision of various lesions in Coccyx
206. Arthroscopic knee aspiration
207. Surgery for meniscus tear
208. Arthroscopic repair of ACL tear KNEE
209. Closed reduction of minor fractures
210. Arthroscopic repair of PCL tear KNEE
211. Tendon shortening
212. Arthroscopic meniscectomy - KNEE
213. Treatment of clavicle dislocation
214. Haemarthrosis KNEE- lavage
215. Abscess KNEE joint drainage
216. Carpal tunnel release
217. Closed reduction of minor dislocation
218. Repair of KNEE cap tendon
219. ORIF with K wire fixation- small bones
220. Release of midfoot joint
221. ORIF with plating- small long bones
222. Implant removal minor
223. K wire removal
224. POP application
225. Closed reduction and external fixation
226. Arthrotomy hip joint
227. Syme's amputation
228. Arthroplasty
229. Partial removal of RIB
230. Treatment of sesamoid bone fracture
231. Shoulder arthroscopy / surgery
232. Elbow arthroscopy
233. Amputation of metacarpal bone
234. Release of thumb contracture
235. Incision of foot fascia
236. Calcaneum SPUR hydrocort injection
237. Ganglion wrist hyalase injection
238. Partial removal of metatarsal
239. Repair / graft of foot tendon
240. Revision/removal of knee cap
241. Amputation follow-up surgery
242. Exploration of ankle joint
243. Remove/graft leg bone lesion
244. Repair/graft achilles tendon
245. Remove of tissue expander

246. Biopsy elbow joint lining
247. Removal of wrist prosthesis
248. Biopsy finger joint lining
249. Tendon lengthening
250. Treatment of shoulder dislocation
251. Lengthening of hand tendon
252. Removal of elbow bursa
253. Fixation of knee joint
254. Treatment of foot dislocation
255. Surgery of bunion
256. Intra articular steroid injection
257. Tendon transfer procedure
258. Removal of knee cap bursa
259. Treatment of fracture of ULNA
260. Treatment of scapula fracture
261. Removal of tumor of arm/ elbow under RA/GA
262. Repair of ruptured tendon
263. Decompress forearm space
264. Revision of neck muscle (torticollis release)
265. Lengthening of thigh tendons
266. Treatment fracture of radius & ulna
267. Repair of knee joint

Critical Care Related:

268. Insert Non- Tunnel CV cath
269. Insert PICC cath (Peripherally Inserted Central Catheter)
270. Insertion Catheter, Intra Anterior
271. Replace PICC cath (Peripherally Inserted Central Catheter)
272. Insertion of Portacath

Dental Related:

273. Splinting of avulsed teeth
274. Suturing lacerated lip
275. Suturing oral mucosa
276. Oral biopsy in case of abnormal
277. tissue presentation
278. FNAC
279. Smear from oral cavity

ENT Related:

280. Myringotomy with grommet insertion
281. Keratosis removal under GA
282. Adenoidectomy
283. Labyrinthectomy for severe vertigo
284. Stapedectomy under GA
285. Stapedectomy under LA
286. Tympanoplasty (type - IV)
287. Endolymphatic sac surgery for meniere's disease
288. Turbinectomy
289. Endoscopic stapedectomy
290. Incision and drainage of perichondritis
291. Septoplasty
292. Vestibular nerve section
293. Thyroplasty type - I
294. Pseudocyst of the pinna - excision
295. Incision and drainage - haematoma auricle
296. Tympanoplasty (type - II)
297. Reduction of fracture of nasal bone
298. Thyroplasty type - II
299. Tracheostomy
300. Excision of angioma septum
301. Turbinoplasty
302. Incision & drainage of retro pharyngeal abscess
303. UVULO palato pharyngo plasty
304. Adenoidectomy with grommet insertion
305. Adenoidectomy without grommet insertion
306. Vocal cord lateralisation procedure
307. Incision & drainage of para pharyngeal abscess
308. Tracheoplasty

Gastroenterology Related

309. Pancreatic pseudocyst EUS & drainage
310. RF ablation for barrett's oesophagus
311. ERCP and papillotomy
312. Esophagoscope and sclerosant injection
313. EUS + submucosal resection
314. Construction of gastrostomy tube
315. EUS + aspiration pancreatic CYST
316. Small bowel endoscopy (therapeutic)
317. Colonoscopy, lesion removal
318. ERCP
319. Percutaneous endoscopic gastrostomy
320. EUS and pancreatic pseudo CYST drainage
321. ERCP and choledochoscopy
322. Proctosigmoidoscopy volvulus detorsion
323. ERCP and sphincterotomy
324. Esophageal stent placement
325. ERCP + placement of biliary stents
326. Sigmoidoscopy W / stent
327. EUS + coeliac node biopsy
328. UGI scopy and injection of adrenaline, sclerosants bleeding ulcers

General Surgery Related:

329. Fissure in ANO sphincterotomy
330. Incision of the breast abscess
331. Surgical treatment of haemorrhoids
332. Infected keloid excision
333. Axillary lymphadenectomy
334. Wound debridement and cover
335. Abscess-decompression
336. Cervical lymphadenectomy
337. Infected sebaceous CYST
338. Inguinal lymphadenectomy
339. Incision and drainage of abscess
340. Suturing of lacerations
341. SCALP suturing
342. Infected lipoma excision
343. Maximal anal dilatation
344. Piles
    A) injection sclerotherapy
    B) piles banding
345. Liver abscess- catheter drainage
346. Fissure in ANO- fissurectomy
347. Fibroadenoma breast excision
348. Oesophageal varices sclerotherapy
349. ERCP - pancreatic duct stone removal
350. Perianal abscess I&D
351. Perianal hematoma evacuation
352. Ugi scopy and polypectomy oesophagus
353. Breast abscess I & D
354. Feeding gastrostomy
355. Oesophagoscopy and biopsy of growth oesophagus
356. ERCP - bile duct stone removal
357. Ileostomy closure
358. Colonoscopy
359. Polypectomy colon
360. Splenic abscesses laparoscopic drainage
361. UGI scopy and polypectomy stomach
362. Rigid oesophagoscopy for FB removal
363. Feeding jejunostomy
364. Colostomy
365. Ileostomy
366. Colostomy closure
367. Submandibular salivary duct stone removal
368. Pneumatic reduction of intussusception
369. Varicose veins legs – injection sclerotherapy
370. Tips procedure for portal hypertension
371. Rigid oesophagoscopy for plummer vinson syndrome
372. Pancreatic pseudocysts endoscopic drainage
373. Zadek's nail bed excision
374. Subcutaneous mastectomy
375. Excision of ranula under GA
376. Rigid oesophagoscopy for dilation of benign strictures
377. Eversion of SAC unilateral/ bilateral
378. Lord's plication
379. Jaboulay's procedure
380. Scrotoplasty
381. Circumcision for trauma
382. Meatoplasty
383. Intersphincteric abscess incision and drainage
384. PSOAS abscess incision and drainage
385. Thyroid abscess incision and drainage

386. Tips procedure for portal hypertension
387. Esophageal growth stent
388. Pair procedure of hydatid CYST liver
389. Tru cut liver biopsy
390. Photodynamic therapy or esophageal tumour and lung tumour
391. Excision of cervical RIB
392. Laparoscopic reduction of intussusception
393. Microdochectomy breast
394. Surgery for fracture penis
395. Sentinel node biopsy
396. Parastomal hernia
397. Revision colostomy
398. Prolapsed colostomy - correction
399. Testicular biopsy
400. Laparoscopic cardiomyotomy (hellers)
401. Sentinel node biopsy malignant melanoma
402. Laparoscopic pyloromyotomy (ramstedt)
403. Excision of fistula-in-ANO
404. Excision juvenile polyps rectum
405. Vaginoplasty
406. Dilatation of accidental caustic stricture oesophageal
407. Presacral teratomas excision
408. Removal of vesical stone
409. Excision sigmoid polyp
410. Sternomastoid tenotomy
411. Infantile hypertrophic pyloric stenosis pyloromyotomy
412. Excision of soft tissue rhabdomyosarcoma
413. Mediastinal lymph node biopsy
414. High orchidectomy for testis tumours
415. Excision of cervical teratoma
416. Rectal-myomectomy
417. Rectal prolapse (delorme's procedure)
418. Detorsion of torsion testis
419. EUA + biopsy multiple fistula in ANO
420. Cystic hygroma – injection treatment

Neurology Related:

421. Facial nerve physiotherapy
422. Nerve biopsy
423. Muscle biopsy
424. Epidural steroid injection
425. Glycerol rhizotomy
426. Spinal cord stimulation
427. Motor cortex stimulation
428. Stereotactic radiosurgery
429. Percutaneous cordotomy
430. Intrathecal baclofen therapy
431. Entrapment neuropathy release
432. Diagnostic cerebral angiography
433. VP shunt
434. Ventriculoatrial shunt

Oncology Related:

435. IV push chemotherapy
436. HBI-hemibody radiotherapy
437. Infusional targeted therapy
438. SRT-stereotactic arc therapy
439. SC administration of growth factors
440. Continuous infusional chemotherapy
441. Infusional chemotherapy
442. CCRT - concurrent chemo + RT
443. 2D radiotherapy
444. 3D conformal radiotherapy
445. IGRT - image guided radiotherapy
446. IMRT- step & shoot
447. Infusional bisphosphonates
448. IMRT - DMLC
449. Rotational ARC therapy
450. Tele gamma therapy
451. FSRT-fractionated SRT
452. VMAT-volumetric modulated arc therapy
453. SBRT-stereotactic body radiotherapy
454. Helical tomotherapy
455. SRS-stereotactic radiosurgery
456. X-knife SRS
457. Gammaknife SRS
458. TBI- total body radiotherapy
459. Intraluminal brachytherapy
460. Electron therapy
461. TSET-total electron skin therapy
462. Extracorporeal irradiation of blood products
463. Telecobalt therapy
464. Telecesium therapy
465. External mould brachytherapy
466. Interstitial brachytherapy
467. Intracavity brachytherapy
468. 3D brachytherapy
469. Implant brachytherapy
470. Intravesical brachytherapy
471. Adjuvant radiotherapy
472. Afterloading catheter brachytherapy
473. Conditioning radiothearpy for BMT
474. Extracorporeal irradiation to the homologous bone grafts
475. Radical chemotherapy
476. Neoadjuvant radiotherapy
477. LDR brachytherapy
478. Palliative radiotherapy
479. Radical radiotherapy
480. Palliative chemotherapy
481. Template brachytherapy
482. Neoadjuvant chemotherapy
483. Adjuvant chemotherapy
484. Induction chemotherapy
485. Consolidation chemotherapy
486. Maintenance chemotherapy
487. HDR brachytherapy

Operations on the tongue:

488. Small reconstruction of the tongue

Ophthalmology Related:

489. Biopsy of tear gland
490. Treatment of retinal lesion

Plastic surgery Related: mouth & face:

491. Construction skin pedicle flap
492. Gluteal pressure ulcer-excision
493. Muscle-skin graft, leg
494. Removal of bone for graft
495. Muscle-skin graft duct fistula
496. Removal cartilage graft
497. Myocutaneous flap
498. Fibro myocutaneous flap
499. Breast reconstruction surgery after mastectomy
500. Sling operation for facial palsy
501. Split skin grafting under RA
502. Wolfe skin graft
503. Plastic surgery to the floor of the mouth under GA

Thoracic surgery Related:

504. Thoracoscopy and lung biopsy
505. Excision of cervical sympathetic chain thoracoscopic
506. Laser ablation of barrett's oesophagus
507. Pleurodesis
508. Thoracoscopy and pleural biopsy
509. EBUS + biopsy
510. Thoracoscopy ligation thoracic duct
511. Thoracoscopy assisted empyaema drainage

Urology Related:

512. Biopsy oftemporal artery for various lesions
513. AV fistula – wrist
514. URSL with stenting
515. URSL with lithotripsy
516. Cystoscopic litholapaxy
517. ESWL
518. Bladder neck incision
519. Cystoscopy & biopsy
520. AV fistula - wrist
521. Cystoscopy and removal of polyp
522. Suprapubic cystostomy
523. Percutaneous nephrostomy

524. Cystoscopy and “sling” procedure
525. Tuna- prostate
526. Excision of urethral diverticulum
527. Removal of urethral stone
528. Excision of urethral prolapse
529. Mega-ureter reconstruction
530. Kidney renoscopy and biopsy
531. Ureter endoscopy and treatment
532. Vesico ureteric reflux correction
533. Surgery for pelvi ureteric junction obstruction
534. Anderson hynes operation (open pyelopalsty)
535. Kidney endoscopy and biopsy
536. Paraphimosis surgery
537. Injury prepuce - circumcision
538. Frenular tear repair
539. Meatotomy for meatal stenosis
540. Surgery for fournier’s gangrene scrotum
541. Surgery filarial scrotum
542. Surgery for watering CAN perineum
543. Repair of penile torsion
544. Drainage of prostate abscess
545. Orchiectomy
546. Cystoscopy and removal of FB

Annexure – III:

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief					
Your Coverage Details:	**Identify your Plan**	**Protect**	**Plus**	**Preferred**	**Premier**	**Accumulate**
Basic Cover This section lists the Basic benefits available on your plan	Identify your Opted Sum Insured (SI)	₹ 2.5 Lacs ₹ 3.5 Lacs ₹ 4.5 Lacs, ₹ 5.5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	₹ 4.5 Lacs, ₹ 5.5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	₹ 15 Lacs, ₹ 30 Lacs, ₹ 50 Lacs	₹ 100 Lacs	₹ 5.5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 50 Lacs
	Inpatient Hospitalisation (When you are hospitalized)	For Sum Insured up to ₹ 5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹ 7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category	Covered up to any Room Category except Suite or higher category			For Sum Insured ₹ 5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹ 7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category
	Pre - hospitalization	Medical Expenses Covered up to 60 days before date of hospitalisation				
	Post - hospitalization	Medical Expenses Covered up to 90 days post discharge from hospital	Medical Expenses Covered up to 180 days post discharge from hospital			Covered up to 90 days post discharge from hospital
	Day Care Treatment	Covered up to the limit of Sum Insured opted				
	Domiciliary Treatment (Treatment at Home)	Covered up to the limit of Sum Insured opted				
	Ambulance Cover (Reimbursement of Ambulance Expenses)	Up to ₹ 2000 paid per hospitalization event	Up to ₹ 3000 paid per hospitalization event	Actual incurred expenses paid per hospitalization event		Up to ₹ 2000 per hospitalization event
	Donor Expenses (Hospitalisation Expenses of the donor providing the organ)	Covered up to full Sum Insured				
	Worldwide Emergency Cover (Outside India)	Covered up to full Sum Insured once in a Policy Year				
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for unrelated illnesses in addition to the Sum Insured opted				
	AYUSH Cover	Covered up to full Sum Insured				

<table>
<tr><td rowspan="6"></td><td>Health Maintenance Benefit
(Treatment that does not require hospitalization and can be carried out in an Out Patient Department)</td><td>Covered up to ₹ 500 per policy year</td><td>Covered up to ₹ 2000 per policy year</td><td colspan="2">Covered up to ₹ 15000 per policy year.</td><td>Option to choose from - ₹ 5000, ₹ 10000, ₹ 15000, ₹ 20000 Per policy Year. Can also be used to pay for Co-pay or Deductible. Up to 50% of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy</td></tr>
<tr><td>Cumulative Bonus on Health Maintenance Benefit</td><td>NA</td><td>NA</td><td colspan="2">NA</td><td>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.</td></tr>
<tr><td>Maternity Expenses</td><td rowspan="3">Not Available</td><td>Covered upto ₹ 15,000 for normal delivery and ₹ 25,000 for C- Section per event, after a Waiting Period of 48 months</td><td>Covered upto ₹ 50,000 for normal delivery and ₹ 100,000 for C-Section per event, after a waiting Period of 48 months</td><td>Covered upto ₹ 100,000 for normal delivery and ₹ 200,000 for C-Section per event, after a waiting Period of 48 months</td><td rowspan="3">Not Available</td></tr>
<tr><td>New Born Baby Expenses</td><td colspan="3">Covered for the inpatient hospitalisation expenses of a new born up to the limit provided under Maternity Expenses</td></tr>
<tr><td>First Year Vaccinations</td><td colspan="3">Covered as per national immunization programme over and above Maternity Sum Insured</td></tr>
<tr><td rowspan="4">Value Added Covers

This section lists the additional value added benefits that are available along with your plan</td><td>Health Check-Up</td><td>Available once every 3rd Policy year to all insured persons who have complet-ed 18 years of Age</td><td colspan="3">Available each policy year(excluding the first year) , to all insured persons who have completed 18 years of Age</td><td>Available once every 3rd Policy year to all insured persons who have complet-ed 18 years of Age</td></tr>
<tr><td>Expert Opinion on Critical illness
(By a Specialist)</td><td colspan="5">Available once during the Policy Year</td></tr>
<tr><td>Cumulative Bonus</td><td>A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.</td><td colspan="3">A guaranteed 10% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured</td><td>A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.</td></tr>
<tr><td>Healthy Rewards</td><td colspan="5">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 against payable premium (including Taxes) from 1st Renewal of the Policy. 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.</td></tr>
</table>

Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Hospital Daily Cash Benefit	₹ 1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹ 2000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹ 3000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹ 1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year
	Deductible (Please select the Sum Insured and Deductible amount as you have opted on the Policy. Deductible is the amount beyond which a claim will be payable in the Policy)	₹ 1/ 2/ 3/ 4/ 5/ 7.5 /10 Lacs	₹ 1/ 2/ 3 / 4 / 5 / 7.5 / 10 Lacs	Not Available	₹ 0.5, 1/ 2/ 3/ 4/ 5/ 7.5 / 10 Lacs
	Waiver of Deductible:	Available	Available	Not Available	Available
	Reduction in Maternity Waiting	Not Available	Maternity waiting period Reduced from 48 months to 24 months		Not Available
	Voluntary Co-pay (The cost sharing percentage that you have opted will apply on each claim.) If you have opted for a Deductible, Voluntary Co-payment does not apply	10% or 20% Voluntary Co-payment for each and every claim as opted		Not Available	10% or 20% voluntary co-payment for each and every claim as opted on the Policy
	Waiver of Mandatory Co-pay	Waiver of Mandatory co-payment of 20% for Insured Persons aged 65 years and above			
	Cumulative Bonus booster	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured		Not Available	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured
Add on cover (Rider) This section lists the Add on cover available under your plan	Critical Illness	Lump sum payment of an additional 100% of Sum Insured Opted		Not Available	Lump sum payment of an additional 100% of Sum Insured Opted

Annexure IV

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

(This list is not applicable for claims under Health Maintenance Benefit)

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

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

Sno	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE I ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN

15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES I ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS I VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES I MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND I NAME TAG
37	PULSEOXYMETER CHARGES

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

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

List IV- Items that are to be subsumed into costs of treatment

Sno	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPO EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTIONISTERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

ManipalCigna Critical Illness Add On Cover

Terms and Conditions

I. General Provisions

1. It is agreed and understood that the Add On Cover can only be bought along with the Underlying Plan and cannot be bought in isolation or as a separate product.
2. The Add On Cover is subject to the terms and conditions stated below and the Policy terms, conditions and applicable endorsements of the Underlying Plan.
3. The Add On Cover shall be available under your policy only if the same is specifically opted and specified in the Policy Schedule.
4. All applicable Terms and Conditions of the Underlying Policy shall apply to the Add On Cover.

II. Definitions

1. **Add On Cover** means ManipalCigna Critical Illness Add On Cover
2. **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. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded -

1. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification
8. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
9. All tumors in the presence of HIV infection

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

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

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

c) Open Chest CABG

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

The following are excluded:

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

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 embolisation 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 Neuron Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

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

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

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

3. Underlying Policy - means the Insurance Policy or any other insurance plan issued by ManipalCignaHealth Insurance including its terms and conditions, any annexure thereto and the Schedule (as amended from time to time), the statements in the proposal form or the Customer Information Sheet and the Policy wording (including endorsements, if any) and to which this Add On Cover is attached.

III. Coverage

a) We will pay a fixed lump sum amount, to the Insured Person suffering from a disease/ Illness/ Injury or medical condition which shall lead to the diagnosis of the named Critical Illnesses or the performance of any of the named Surgical Procedures listed and defined under this Add on.

i. Cancer of Specified Severity

ii. Myocardial Infarction (First Heart Attack of Specific Severity)

iii. Open Chest CABG

iv. Open Heart Replacement or Repair of Heart Valves

v. Coma of Specified Severity

vi. Kidney Failure Requiring Regular Dialysis

vii. Stroke Resulting in Permanent Symptoms

viii. Major Organ/Bone Marrow Transplant

ix. Permanent Paralysis of Limbs

x. Motor Neuron Disease with Permanent Symptoms

xi. Multiple Sclerosis with Persisting Symptoms

b) The Sum Insured will be payable once in a lifetime of an Insured subject to the following conditions:

i. The Critical Illness is specifically listed and defined in this Cover;

ii. The Critical Illness experienced by the Insured person is the first incidence of that Critical Illness;

iii. The Insured Person survives for at least 30 days following the diagnosis of Critical Illness;

iv. The Insured Person is at least 18 years of age at the time of taking the Cover.

v. Coverage will not apply to persons between the age group of 18 to 23 years who are covered as “Child”.

vi. Once a claim has been accepted and paid for a particular Critical Illness for that particular Insured, the cover shall cease in respect of that Insured Person.

In case of a floater policy, We will provide for a 100% reinstatement of Sum Insured once during the lifetime of the Policy for the other adult Insured Person in the Policy.

“Reinstatement of Sum Insured” for the purpose of this Policy means the amount reinstated in accordance with the terms and conditions as stated above under this Policy.

Discounts

1. Family Discount: Discount of 10% on the premium for covering 3 or more individuals with individual sum insured.
2. Long Term Discount: Long term discount, on the premium, of 7.5% for selecting a 2 year policy term and 10% for selecting 3 year policy term. The discount is available only with ‘Single’ premium payment mode.
3. Direct Policy Discount: Discount of 10% on the premium for policies issued directly without the involvement of any intermediary.
4. Worksite Marketing Discount: Discount of up to 10%, on the premium, will be available on polices sourced through worksite marketing channel.
5. Social Media Discount: Discount of 2.5%, on the premium will be available on policies sourced through online channel and policyholder opts to post the pre-defined marketing message to all contacts in his social media account.

IV Waiting Periods

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

a) **First 90 days Waiting Period:** Any Critical Illness or Injury which was diagnosed or existed within the first ninety (90) days of the Add On Cover start date will not be covered.

b) **Pre-existing disease Waiting period:** Any Pre-existing Critical Illness as defined in the Policy until the specified months of continuous covers have elapsed since inception of the first Policy with Us. Waiting period for the specified months as mentioned in the Schedule against this Benefit shall apply.

Pre-existing disease for the purpose of this waiting period is defined as below:

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

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

or

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

c) **Personal Waiting Period:** A special Waiting Period not exceeding 48 months, may be applied to Insured Persons 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 the Insured Person’s specific consent.

V. Survival Period

The benefit payment shall be subject to survival of the Insured Person for more than 30 days post the first diagnosis of the Critical Illness/ undergoing for the first time of the Surgical Procedures/ for the first time of occurrence of medical events.

VI Cancellations

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

1 Year		2 year		3 year	
Policy in force upto	**Premium Refund %**	**Policy in force upto**	**Premium Refund %**	**Policy in force upto**	**Premium Refund %**
1 month	75%	1 month	87.5%	1 month	90%
3 months	50%	3 months	75%	3 months	85%
6 months	25%	6 months	62.5%	6 months	75%
More than 6 months	NIL	12 months	50%	12 months	60%
		15 months	37.50%	15 months	50%
		18 months	25%	18 months	35%
		Above 18 months	NIL	24 months	30%

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-cooperation by You without any refund of premium.

Where the Policy has been issued for two years and a claim for Critical Illness becomes payable in the first year the cover shall cease and any premium collected for the second year in respect of a particular Insured Person will be refunded after deduction of applicable discounts and commissions (if any).

VII. Permanent Exclusions

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

1. Any Illness, sickness or disease, other than specified as Critical Illness, as mentioned in the Schedule;
2. Any Critical Illness 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;
3. Any Critical Illness arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen;
4. Any Critical Illness directly or indirectly caused due to Intentional selfinjury, suicide or attempted suicide.
5. Any treatment/surgery for change of sex or any cosmetic surgery or treatment/surgery /complications/illness arising as a consequence thereof;
6. 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;
7. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
8. Congenital anomalies or any complications or conditions arising therefrom;
9. 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;
10. Any loss resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy;
11. Any Critical Illness based on 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 kind of self-medication and its complications;
12. Cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non-surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control programs, or treatment of an optional nature;
13. Any critical illness arising or resulting from the Proposer or any of his family members committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion; In the event of death of the Insured within the stipulated survival period applicable under each category. Applicable exclusions of the Underlying Policy will apply in addition to the Add On exclusions.

VIII Claim Process

In the event of a claim arising out of any of the listed Critical Illnesses covered under this Add on, the Insured Person shall submit the claim documents to Us within ninety (90) days of date of first diagnosis of the Illness/ date of surgical procedure or date of occurrence of the medical event, as the case may be. Insured Person shall submit the following documents in original for assessment and upon request we will return the Original documents.

1. Claim Form Duly Filled and Signed- Part Aand B
2. Original Discharge Certificate/ Card from the hospital/ Doctor
3. Original investigation test reports confirming the diagnosis, Indoor case papers if applicable
4. Any other documents as may be required by Us
5. In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will be required.

In the unfortunate event of the death of the Insured Person post the survival period, someone claiming on his behalf must inform Us in writing immediately.

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

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

Manipal Cigna
Health Insurance

For any assistance contact: 1800-102-4462 servicesupport@manipalcigna.com www.manipalcigna.com

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