MANIPALCIGNA GLOBAL HEALTH GROUP POLICY

Policy Contract

B Preamble

This Policy is a contract of insurance between You and Us which is subject to (a) the terms, conditions and exclusions of this Policy and (b) the receipt of Premium against each Benefit of the applicable in full and (c) the Disclosure to information norm (including by way of the Proposal or Information Summary Sheet) in respect of all Insured Persons and (d) the Policy Schedule/ Certificate of Insurance.

C Definitions

C.I Standard Definitions

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

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

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

Cashless facility: 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 is approved.

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

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

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body

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

Day Care Centre: Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical set-up with 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 criterion as under:-

- has qualified nursing staff under its employment;
- has qualified medical practitioner(s) in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

In respect of US based admissions, this also includes Surgical Procedures carried out in the Medical Practitioner's surgery.

Day Care Treatment: Day care treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

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

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

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

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

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

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

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

Group: Group - consists of persons who join with a commonality of purpose or engaging in a common economic activity and includes employer - employee group and non-employer - employee group:

a. Employer-employee group is a group where an employer-employee relationship exists between the master policyholder and the member in accordance with the applicable laws.

b. Non-Employer-employee group is a group other than employer-employee where a clearly evident relationship between the member and the group policyholder exists for services/activities other than insurance.

Hospital (India): A Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56 (1) of the said act Or complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- 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 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.

Note: For the purpose of this Policy, a Hospital situated outside India shall refer to any equivalent institution organisation established for in-patient care and day care and treatment of Injury or Illness and which has been registered or licensed as a medical or surgical hospital or clinic as per the applicable law, rules and/or regulations in the country in which it is located and where the patient is under the care or supervision of a Medical Practitioner or Qualified Nurse and does not include a nursing home.

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

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

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

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

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

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

In-patient Care: In-patient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

Intensive Care Unit (ICU): 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.

Maternity expenses: Maternity expenses means:

- medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- expenses towards lawful medical termination of pregnancy during the policy period.

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

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

Medical Practitioner: Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or appropriate authority of the country where Insured Person is availing treatment outside India/Country of origin and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Medically Necessary: Medically necessary treatment 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.

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

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

New Born Baby: Newborn baby means baby born during the Policy Period and is aged upto 90 days.

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

OPD treatment: OPD treatment means the one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Pre-Existing Disease: Pre-existing disease (PED)-means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Portability: Portability-means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

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

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

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

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

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

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

Qualified Nurse: Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India; or is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided when outside of India.

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

Renewal: Renewal means the terms on which the contract of 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.

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

Senior Citizen: "senior citizen" means any person being a citizen of India, who has attained the age of sixty years or above. (Reference: Maintenance and Welfare of Parents and Senior Citizens Act, 2007.)

Specific Waiting Period: means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

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

Unproven / Experimental Treatment: Unproven / Experimental Treatment means treatment including drug experimental therapy which is not based on established medical practice in India, or in country specified in the Policy Schedule, is treatment experimental or unproven.

C.II Specific Definitions

Age: Age or Aged means the completed age as on the last birthday.

Non-Allopathic Treatment: Non-Allopathic treatment means any line of treatment other than the allopathic line of medicine/ treatment.

Area of Cover: Area of Cover means the geographic coverage area as defined under the Policy and as particularly specified for the Insured Person in the Policy Schedule/Certificate of Insurance.

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

Annexure: Annexure means a document attached as a part to this Policy and marked as Annexure.

Annual Renewal Date: Annual Renewal Date means the anniversary of the Inception date each year or any other date which We agree with you in writing.

AYUSH Treatment: AYUSH Treatment refers to the medical and /or Hospitalization Treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems provided the treatment has been undergone in (in India):

i) Teaching hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)

ii) AYUSH Hospitals having registration with a Government authority under appropriate Act in the state/UT and complies with the following as minimum criteria:

   a. Has at least fifteen in-patient beds
   b. Has minimum five qualified and registered AYUSH doctors
   c. Has qualified paramedical staff under its employment round the clock
   d. Has dedicated AYUSH therapy sections;
   e. Maintains daily record of patients and makes these accessible to the insurance company's authorized personnel.

AYUSH Day Care Centre: means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with the following criterion:

i. having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. having dedicated AYUSH therapy sections as required and/ or has equipped operation theatre where surgical procedures are to be carried out;
iii. maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

Benefit: Benefit means any benefit under the Policy, as opted and available for the Insured Person and specified in the list of benefits in the Policy Schedule/Certificate of Insurance.

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

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

Complementary treatment: Complementary treatment means:

- Physiotherapy

Treatment of an Illness, Injury or deformity through physical methods such as massage, heat treatment, etc.

- Acupressure

The application of pressure (as with the thumbs or fingertips) to the same discrete points on the body stimulated in acupuncture that is used for its therapeutic effects (such as the relief of tension or pain).

- Acupuncture

Acupuncture is a form of alternative medicine in which thin needles are inserted into the body for treatment of various physical and mental conditions.

- Chiropody

A specialty supplementary to medicine devoted to the care of the feet and the treatment of minor foot complaints such as ingrowing toenails, bunions, plantar warts, foot strain, flat feet and the care of the feet of diabetics.

- Chiropractic

A system that, in theory, uses the recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body, particularly of the spinal column and the nervous system,

in the restoration and maintenance of health.

- Osteopathy

A system of medicine based on the theory that disturbances in the musculoskeletal system affect other bodily parts, causing many disorders that can be corrected by various manipulative techniques in conjunction with conventional medical, surgical, pharmacological and other therapeutic procedures.

- Homeopathy

A system of complementary medicine in which ailments are treated by minute doses of natural substances that in larger amounts would produce symptoms of the ailment.

- Ayurveda

A science of life based on the Vedas, the Hindu books of knowledge and wisdom. It is the traditional Hindu system of medicine (incorporated in Vedas), which provides an integrated approach for prevention and treatment of illness trough lifestyle interventions and natural therapies.

Contribution: Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured Person to share the cost of an indemnity claim on a ratable proportion of the Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

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

Critical Illness: Critical Illness shall mean Illnesses listed below or as customized for a Policy and specified under the Policy Schedule/ Certificate of Insurance.

- Cancer of Specified Severity	- Aorta Graft Surgery	- Apallic Syndrome
- Myocardial Infarction (First Heart Attack-of Specific Severity)	- Deafness (Loss of Hearing)	- Parkinson's Disease
- Open Chest CABG	- Blindness (Loss of Sight)	- Medullary Cystic Disease
- Open Heart Replacement or Repair of Heart Valves	- Aplastic Anaemia	- Muscular Dystrophy
- Coma of Specified Severity	- Coronary Artery Disease	- Loss of Speech
- Kidney Failure Requiring Regular Dialysis	- End Stage Lung Disease	- Systemic Lupus Erythematous
- Stroke Resulting in Permanent Symptoms	- End Stage Liver Failure	- Loss of Limbs
- Major Organ/ Bone Marrow Transplant	- Third Degree Burns (Major Burns)	- Major Head Trauma
- Permanent Paralysis of Limbs	- Fulminant Hepatitis	- Brain Surgery
- Motor Neurone Disease with Permanent Symptoms	- Alzheimer's Disease	- Cardiomyopathy
- Multiple Sclerosis with Persisting Symptoms	- Bacterial Meningitis	- Creutzfeldt-Jacob Disease (CJD)
- Primary Pulmonary Hypertension	- Benign Brain Tumour	- Terminal Illness

Dentist: Dentist - a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided.

Dependent: Dependent means the member's spouse or unmarried, civil/contractual partner or child or parent who has been enrolled in the Policy.

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

Eligible Female: Eligible Female is a person who is a female member or a female Spouse or unmarried, civil/contractual partner of a member.

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

Employee: Employee means any member of Your staff who is proposed and sponsored by You who becomes an Insured Person.

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

HDU: HDU means the High Dependency Unit, an area in a Hospital, usually located closely to the ICU where patients can be cared for more extensively than a normal ward but not to the point of intensive care.

Inception Date: Inception Date means the inception date of this Policy as specified in the Policy Schedule when the coverage under the Policy becomes effective for the Insured Persons and their dependents (if any).

In-patient: In-patient means an Insured Person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving treatment.

Insured Person: Insured Person means the member or Dependents named in the Policy Schedule, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate Premium paid.

Medical Assistance Service: Medical Assistance Service is a service which provides medical advice, evacuation, assistance and repatriation. This service can be multi-lingual and assistance is available 24 hours per day.

Minor Surgical Procedures and Associated Treatments: Minor Surgical Procedures and Associated Treatments are any surgical Treatments or Surgical Procedures that do not require a general anaesthetic or overnight Hospital stay, e.g. surgical treatment of an ingrown toe nail.

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

Operation: Operation means a procedure performed on a living body usually with instruments for the repair of damage or the restoration of health and especially one that involves incision, excision, or suturing.

Out-Patient: Out-Patient means a patient who undergoes OPD treatment.

Policy: Policy comprises of Policy wordings, Certificates of Insurance issued to the Insured Persons, group Proposal Form/Enrolment Form and Policy Schedule which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.

Policy Period: Policy Period means the period between the Inception Date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

Policy Schedule: Policy Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the available Sum Insured under a Benefit or a set of Benefits, the Policy Period and the Sub-limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Policy Year: Policy Year means a period of 12 consecutive months within the Policy Period commencing from the Inception Date or any subsequent Policy anniversary.

Premium: Premium shall have to be paid in Indian Rupees and made in favour of ManipalCigna Health Insurance Company Ltd.

Private Room: Private Room means a single occupancy accommodation in a private hospital.

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

Specialist Specialist is a Medical Practitioner who:

- Has received advanced specialist training
- Practices a particular branch of medicine or surgery
- Holds or has held a consultant appointment in a Hospital or an appointment which We accepts as being of equivalent status.
- A physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided is only a specialist for the purpose of physiotherapy as described in the list of Benefits.

Spouse: Spouse means the member's legal husband or wife accepted for cover under the Policy.

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

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

Surgical appliance and/or Medical Appliance: Surgical appliance and/or Medical Appliance:

- An artificial limb, prosthesis or device which is required for the purpose of or in connection with surgery
- An artificial device or prosthesis which is a necessary part of the treatment immediately following Surgery for as long as required by medical necessity.
- A prosthesis or appliance which is medically necessary and is part of the recuperation process on a short-term basis.'

TPA: Third Party Administrator (TPA) means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under these regulations.

Trauma inducing event: Trauma inducing events means an event/ incident that causes physical, emotional, spiritual, or psychological harm. The person experiencing the distressing event may feel threatened, anxious, or frightened as a result. In some cases, they may not know how to respond, or may be in denial about the effect such an event has had.

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

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

D. Benefits covered under the policy

The Certificate of Insurance will specify which Benefits are in force for the Insured Person during the Period of Insurance. Claims made under any applicable Benefit, for the Period of Insurance will be subject to the terms, conditions and exclusions of this Policy, the availability of the Sum Insured for that Benefit, any applicable Sub-Limits and subject always to the availability of the aggregate limit of the Policy (if applicable and specified in the Policy Schedule/Certificate of Insurance). Claims will be payable in excess of the applicable Deductible specified in the Policy Schedule/ Certificate of Insurance, if any. Where an event qualifies for an indemnity under more than one Benefit with respect to the same risk/ insured event the Insured Person will be eligible for reimbursement under any one of the Benefits.

All claims paid under the Policy will impact the Sum Insured available under the Policy for that Benefit or set of Benefits. All claims on a Cashless Facility basis must be made in accordance with the procedure set out in Section G.I.4, and all reimbursement claims must be made in accordance with the procedure set out in Section G.I.5, unless specified otherwise.

A claim is payable subject to occurrence of a covered event during the Policy Period unless specified otherwise.

Base Covers

D.I BASE 1 (Mandatory)

D.I.1 In-patient Hospitalization and Day Care

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment at a Hospital, for more than 24 consecutive hours/Day Care, arising from an injury due to an Accident or an Illness contracted during the Policy Period, up to the Sum Insured specified under the Policy Schedule/Certificate of Insurance:

i. Room charges up to:
   - Any Hospital Room except suite and above for Hospitalization in India and
   - Any Hospital Room up to Private Room for Hospitalization outside India,

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

iii. Hospitalization charges,

iv. Pre and Post Hospitalisation Expenses

v. Operation theatre cost,

vi. Surgical Procedures,

vii. Minor Surgical Procedures,

viii. Day Care Treatment,

ix. AYUSH Treatment for In-patient Hospitalization & Day Care (In India Only)

x. Medical Practitioner fees,

xi. Specialist fee,

xii. Surgeon's fee,

xiii. Anaesthetist fee,

xiv. Radiologist fee,

xv. Pathologist fee,

xvi. Assistant Surgeon fee,

xvii. Qualified Nurses fee,

xviii. Medication,

xix. Cost of diagnostic tests as an In-patient,

xx. Surgical appliance and/or Medical Appliance.

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

Medical Expenses related to any admission (under In-patient Hospitalization, Day Care Treatment) primarily for enteral feedings will be covered, provided it is Medically Necessary and is prescribed by a Medical Practitioner.

The following procedures will be covered (wherever medically indicated) either as In-patient or as part of day care treatment in a hospital up to the limit as per the plan and sum insured opted in a Policy Year.:

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchial Thermoplasty
j. 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.

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

Medical Expenses incurred for the Medically Necessary Treatment of the Insured Person for Hospitalization arising from or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, sexually transmitted diseases (STD) will be covered up to the Sum Insured opted in a Policy Year. This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time. The necessity of the Hospitalization is to be certified by an authorised Medical Practitioner.

Medical Expenses incurred for the Medically Necessary treatment of the Insured Person for in-patient Hospitalization, arising from or associated with a Mental illness or a medical condition impacting mental health will be covered up to sum insured opted in a Policy Year. This coverage is provided in accordance with The Mental Health Care Act, 2017 as amended from time to time.

If the Insured Person is admitted in a room category or in a room where the Room Rent is higher than the one that is specified in the Policy then the Insured Person shall bear the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.

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

D.I.2. Private Ambulance

We will pay the Reasonable and Customary Charges for costs incurred towards shifting an Insured Person to the Hospital for admission in the Emergency ward or ICU or for shifting the Insured Person from one Hospital to another Hospital for better medical facilities by way of road transport unless otherwise specified under the Policy.

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

D.I.3. Emergency Dental Treatment

In case of an Injury sustained by an Insured Person due to an Accident which requires Emergency Dental Treatment, We shall pay the Reasonable and Customary Charges for the Dental Treatment received by the Insured Person for treatment of such Injury.

The cover is available up to Sum Insured/ limit specified under the Policy Schedule/Certificate of Insurance.

All Claims under this benefit can be made as per the process defined under Section G.I.4 & G.I.5 of 'Policy Terms and Conditions'.

D.I.4. Dental Cover

We will pay the Reasonable and Customary Charges for costs incurred by the Insured Person towards Dental Treatment of the nature specified below, if prescribed by a Medical Practitioner.

All claims under this Benefit can be made as per the process defined under Section G.I.14 of 'Policy Terms and Conditions'.

a. Class 1 (Investigative & Preventative Treatment)

Under this Benefit, We will pay Reasonable and Customary Charges incurred towards the fees of a Dentist and associated costs for carrying out the following routine Dental Treatment procedures in respect of the Insured Person:

- Clinical Oral examinations;
- Palliative treatment for dental pain
- Minor Procedures
- tooth cleaning;
- normal compound fillings; or
- simple non-surgical extractions.

This Benefit excludes orthodontic treatment, restorative treatment and dental implants.

b. Class 2 (Basic Restorative, Periodontal Treatment)

Under this Benefit We will pay the Reasonable and Customary Charges incurred towards the fees of a Dentist and associated costs for carrying out the following specified procedures in respect of the Insured Person:

- Amalgam Filling
- Composite/Resin Filling
- Root Canal Treatment
- Osseous Surgery
- Periodontal Scaling & Root Planning
- Adjustments
- Recement Bridge
- Routine Extractions
- Surgical removal of impacted tooth
- Local or general Anaesthesia including Sedation

This Benefit excludes orthodontic treatment, routine treatment and dental implants.

c. Class 3 (Major Restorative & Orthodontic Treatment)

Under this Benefit We will pay the Reasonable and Customary Charges incurred towards fees of a Dentist carrying out restorative Dental Treatment and associated costs for carrying out the following specified procedures in respect of an Insured Person:

- removal of impacted or buried teeth;
- removal of roots;
- removal of solid odontomes;
- apicectomy;
- new or repair of bridge work;
- new or repair of crowns;
- root canal treatment;
- new or repair of upper or lower dentures;
- removal of wisdom teeth.

Orthodontic treatment of the nature specified above and associated costs shall be available for children below 18 years of Age only if specified to be available under the Benefit in the Policy Schedule/Certificate of Insurance and a pre-authorization is obtained from Us in writing for claims towards the same.

For the purpose of this Benefit, orthodontic treatment shall include Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

This benefit excludes dental implants.

Exclusions Applicable to Dental Cover

We will not be liable to make any payment for the following treatments:

i. replacing any dental appliance which is lost or stolen;

ii. replacing a bridge, crown or denture unless advised by treating doctor due to damage of the old bridge/crown/denture;

iii. replacing a bridge, crown or denture within five years of original fitting unless:

iv. the replacement is needed because of the placement of an original opposing full denture or extraction of natural teeth is needed; or

v. the bridge, crown or denture, while in the mouth, has been damaged beyond repair because of an Injury the member or their Dependent receives while covered under the Policy.

vi. porcelain or acrylic veneers on the upper and lower first, second and third molars and premolars;

vii. crowns or pontics on or replacing the upper and lower first, second and third molars unless-they are constructed of either porcelain bonded-to-metal or metal alone, e.g. gold alloy crown; or a temporary crown or pontic is required as part of routine or Emergency Dental Treatment.

viii. surgical implants of any type including any attaching prosthetic device;

ix. procedures and materials which are experimental or which do not meet accepted dental standards;

x. Any consultation for guidance of plaque control, oral hygiene and diet is excluded;

xi. Any Dental procedures, services and supplies provided in a hospital unless Dental treatment is wholly or partly indicated as a reason for stay in Hospital Example, mouthwashes, mouth paint etc;

xii. bite registration, precision or semi-precision attachments;

xiii. procedures, appliances or restorations (except full dentures) whose main purpose is to:

- change vertical dimensions; or
- diagnose or treat conditions or dysfunction of the temporo-mandibular joint; or
- stabilise periodontally involved teeth; or
- restore occlusion; or
- major treatment on deciduous or baby teeth for Dependent Children.

The cover is available up to Sum Insured/ limit specified under the Policy Schedule/Certificate of Insurance.

D.II. BASE 2

D.II.1. Out-Patient Expenses

We will pay the Reasonable and Customary Charges for the following Out-Patient expenses, in respect of an Insured Person, arising from an injury due to an Accident or an Illness contracted during the Policy Period, if opted and specified under the Policy Schedule/Certificate of Insurance.

i. Consultations with Medical Practitioners and Specialists;

ii. Prescribed medicines, drugs and dressings; expenses towards over the counter (OTC) medicines shall be payable if opted and specified under the Policy Schedule/Certificate of Insurance.

iii. Diagnostic tests such as laboratory tests, radiology and pathology, MRI, CAT scan, PET scan.

The cover is available:

i. only if cover Base 1 is opted under the Policy.

ii. up to Sum Insured/limit specified under the Policy Schedule/ Certificate of Insurance.

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

E Exclusions

All the Waiting Periods shall be applicable individually for each Insured Person since the Inception Date of the first Policy or coverage for the Insured Person **and claims shall be assessed accordingly.**

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 opted, waived, covered or specified under the Policy or any Cover opted under the Policy:

E.I. Standard Exclusions

E.I.1. Pre-Existing Diseases - 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 period (as specified in the Policy Schedule/Certificate of Insurance) 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 number of months as specified in the Policy Schedule/Certificate of Insurance for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

a. Expenses related to the treatment of the listed Conditions, surgeries/ treatments shall be excluded until the expiry of period (as specified in the Policy Schedule/Certificate of Insurance) 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 provided:

i. Cataract,

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

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

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

E.I.3. 30-day waiting period- Code-Excl03

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

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

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

Waiting period under this section will be applicable as opted and specified in the Policy Schedule/Certificate of Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

d. Body Mass Index (BMI);

   i. greater than or equal to 40 or

   ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

   - Obesity-related cardiomyopathy
   - Coronary heart disease
   - Severe Sleep Apnea
   - Uncontrolled Type 2 Diabetes

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

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are excluded, except for sex reassignment surgery for transgender persons.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

E.I.18. Maternity: Code-Excl 18

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

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

E.II. Specific Exclusions

E.II.1. Any form of Non-Allopathic treatment (except AYUSH Treatment) such as Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

E.II.2. Charges incurred towards for residential stays in Hospitals:

i. stay is wholly or partly for domestic reasons and/or

ii. for stay where treatment is not required and/or

iii. where the Hospital has effectively become the place of domicile or permanent abode.

E.II.3. Any treatment directly related to surrogacy. We will not pay for expenses arising in respect of an Insured Person who acts as a surrogate or anyone else acting as a surrogate for an Insured Person.

E.II.4. For claims outside of India, Supportive treatment for chronic kidney failure or kidney failure which cannot be cured. Treatment for kidney dialysis will be covered if such treatment is available in the location of assignment or if not available, treatment will be covered in the patient's country of domicile or centre of excellence nearest the location of assignment. Only treatment costs for kidney dialysis will be covered; travel and accommodation expenses in connection with such treatment

will not be covered.

E.II.5. All expenses, caused by or arising from war or war-like situation, or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

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

E.II.7. Any form of non-emergency travel costs in respect of an Emergency Evacuation or Repatriation specifically payable under International Emergency Services, which is not specified in the Policy Schedule/ Certificate of Insurance or not intimated and approved in advance by Us.

E.II.8. International services expenses for Emergency Evacuation, Medical Repatriation and transportation costs payable to any Service Partner where the treatment needed is not covered under the Plan.

E.II.9. International services expenses related to Medical Repatriation and Evacuation for:

- non-Emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or sickness; or
- a condition which would allow for treatment at a future date convenient to the Insured Person and which does not require emergency evacuation or repatriation; or
- medical care or services scheduled for the patient's or provider's conveniences which are not considered an Emergency

E.II.10. Any expenses for ship-to-shore evacuations.

E.II.11. Expenses relating to:

i. Prostheses which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised

ii. Corrective devices which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised

iii. Medical Appliances, which are not required intra-operatively for the Illness/Injury for which the Insured Person was Hospitalised

iv. 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.

v. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.

E.II.12. Incidental costs including newspapers, taxi fares, telephone calls, guests' meals and hotel accommodation

E.II.13. Costs for treatment that has not yet taken place irrespective of whether advance authorization has been given or a Cashless facility has been put in place.

E.II.14. Costs for Non-Surgical & Minor Surgical Procedures & treatment conducted on Out-patient basis.

E.II.15. Costs associated to palliative care or hospice care.

E.II.16. Expenses in respect of accompanying person including cost of accommodation.

E.II.17. Costs of Nurse visit at home to provide nursing services.

E.II.18. Any claim relating to events occurring before the Inception Date or otherwise outside of the Policy Period.

E.II.19. Any External Congenital Anomalies or any consequence thereof.

E.II.20. Any expenses incurred towards a New Born baby.

E.II.21. Medical Expenses incurred towards the Insured Person when he/ she is outside the Area of Cover specified under the Policy Schedule/ Certificate of Insurance.

E.II.22. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

E.II.23. Issue of medical certificates and examinations as to suitability for employment or travel.

E.II.24. For complete list of Non-medical expenses, refer Annexure II-List I "Non-Medical Expenses" to the Policy and also on Our website.

E.II.25. 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

F. General Terms and Clauses

F.I. Standard General Terms and Clauses

F.I.1. Duty of Disclosure - Disclosure to information norm

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

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

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

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

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

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

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

F.I.4. Complete Discharge

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

F.I.5 Multiple Policies

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

conditions of the chosen policy.

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

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

F.I.6. Fraud

If any claim made by the Insured Person is in any respect fraudulent, or if any false statement or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any Benefit under this Policy then this Policy all benefits under this policy and the premium paid shall be forfeited.

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

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

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

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

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

The Company shall not repudiate the claim and/or forfeit the policy benefits on the 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

F.I.7. Cancellation

i. In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 7 days’ notice in writing. We shall refund the premium for the unexpired policy period as mentioned below:

A. Policy Tenure of 1 Year:

1. If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of the cancellation request will be considered as the expiry date of coverage.
2. If a claim has been made during the Policy period, no refund will be given to the Policyholder.

Illustration:

1. Where Policyholder has not made any claim during the Policy Year.

Policy Start Date	01-07-2023
Policy End Date	30-06-2024
Tenure	1
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	285
Premium Refund	77.87 (100*285/365)

2. Where the Policyholder has made a **claim** during the Policy Year

Policy Start Date	01-07-2023
Policy End Date	30-06-2024
Tenure	1
Latest Claim Date	11-05-2024
Cancellation Request Date	11-06-2024
Premium Collected	100.00
Unexpired Period (in Days)	19
Premium Refund	-

No refund would be given to Policyholder as he had made a claim during the Policy Period.

B. If Policy Tenure is more than 1 years:

1. If no claim has been made in the policy year, a proportionate refund of the premium on cancellation will be issued based on the number of unexpired days. The date of the cancellation will be considered as the expiry date of coverage.
2. If a claim has been made in the current policy year, the premium for the remaining complete policy year(s) will be refunded on cancellation.
3. If a claim has been made in active policy but in previous policy year, a proportionate refund of the premium on cancellation will be issued based on the number of unexpired days. The date of the cancellation will be considered as the expiry date of coverage.

Illustration:

1. Where Policyholder has not made any claim during the Policy Year.

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure	2
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	650
Premium Refund	88.92 (100*650/731)

2. Where the Policyholder has made a **claim** during the Policy Period.

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure	2
Latest Claim Date	11-05-2024
Cancellation Request Date	11-06-2025
Premium Collected	100.00
Unexpired Period (in Days)	19
Premium Refund	2.60 (100*19/731)

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

F.I.8. Migration

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

guidelines on migration.

F.I.9 Portability

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

F.I.10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, misrepresentation, non-disclosure or misrepresentation by the insured person.

i. The Company shall 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, as applicable, days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

F.I.11. Withdrawal of Policy

a. 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.

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

F.I.12. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

F.I.13. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

F.I.14. Free Look period

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

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

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

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

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

F.I.15. Grievances Redressal Procedure

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

Email: servicesupport@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at,

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

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

or

Email: headcustomercare@manipalcigna.com.

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

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

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

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

The office Name and address details applicable for your state can be obtained from - https://bimabharosa.irdai.gov.in/.

F.I.16. Nomination

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

F.II. Specific terms and clauses

F.II.1. Maintenance of Records:

The Insured Person shall maintain all records and books of accounts reasonably required in an accurate manner.

F.II.2. Alterations in the Policy

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

F.II.3. Material Information for administration

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

the details of the Insured Persons to be deleted and the details of the Eligible persons proposed to be added to the Policy as Insured Persons.

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

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

F.II.4. Eligibility

The Policy provides cover on an individual basis where each member has a separate Sum Insured. To be eligible for coverage under the plan, the Insured Person must be-

- A group member/Employee of the Policyholder or non-employer group enrolled member where the group pertains to members/ Employees of a Group/Company.
- The minimum Age of entry for a member, spouse or unmarried, civil/ contractual partner, parent, children, siblings, parent in laws, grandparents, son in-law and daughter in-law, uncle, aunty, grandchildren, nephew & niece for entering into this policy is 18 years and the maximum Age of entry is 95 years. Dependent Children dependent sibling, dependent grandchildren, dependent nephew & dependent niece can be covered from day 1 of birth up to 25 years of Age.
- Renewals will be available for lifetime provided the Insured Person is still employed with/member of the Group and nominated for coverage.
- New Born Baby will be accepted for cover (subject to the limitations of the new born benefit) from birth. Acceptance of New Born Baby as Insured Persons is subject to written notification within 30 days of birth and receipt of the agreed Premium within a further 30 days following notification.

It is clarified that for the purpose of availing this Policy, the Master Policyholder/You shall ensure that the minimum number of Employees/ members who will form a group under this Policy shall be 7 or as prescribed by the IRDAI form time to time.

This Policy shall be applicable in the Area/s of Cover specified in the Policy Schedule/Certificate of Insurance.

F.II.5. Insured Person

Only those persons named as an Insured Person in the Policy Schedule/ Certificate of Insurance shall be covered under this Policy. Any person may be added as an Insured Person during the Policy Period after his application has been accepted by Us, additional Premium to be paid and We have issued an endorsement confirming the addition of such person as an Insured Person under this Policy.

F.II.6. Loading and/or exclusion

On change of the Insured Person's risk profile or the parameters on which Premium is derived the coverage under this Policy may cease, unless specifically agreed by Us. However, in such cases, We may underwrite the case in line with the underwriting policy of the product.

F.II.7. Operation of Policy & Certificate of Insurance

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

F.II.8. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/the Insured Person in possession of any official of Ours shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve the Insured Persons from their duty of disclosure, irrespective of acceptance of Premium by the Us.

F.II.9. Geography

The geographical scope of this Policy applies to events limited to the Area/s of Cover opted and which are specified in the Policy Schedule/ Certificate of Insurance.

F.II.10. Dispute Resolution & Applicable Law

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

F.II.11. Premium

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

If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period. Instalment facility shall not be available for the Policy Tenure more than 1 year.

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

Wherever premium is not received within the grace period of the policy, the policy will be terminated from the date on which such grace period is over to pay the premium and all claims that fall beyond such grace period shall not be covered as part of the policy. However, we will be liable to pay in respect of all claims where the treatment/admission/accident has commenced/occurred before the expiry of such grace period for the payment of instalment premium.

F.II.12. Parties to the Contract

The only parties to this contract are You and Us.

F.II.13. Currency

The monetary limits applicable to this Policy will be expressed in the same currency specified in the Policy Schedule/Certificate of Insurance. Claims paid in a local currency will be converted at the spot exchange rate on the date of payment of expenses.

F.II.14. Addition and Deletion of a Member

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

Additions

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

Deletions

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

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

All addition and deletions that lead to either additional Premium being

applied will be generated at the time of addition of such employees/ members and/or Dependents and the same will be paid before the actual start date of the cover in respect of those employees/members. In case of refund of Premium being generated on the policy due to deletions the same will be refunded or adjusted against future Premium instalments due on the policy.

F.II.15. No Constructive Notice

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

F.II.16. Grace Period & Renewal

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

i. The Company shall endeavor to give notice for renewal at least 30 days in advance from the Policy due date.

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

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

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

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

Renewal Terms:

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

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

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

Revival Period:

Instalment (less than annual) premium policies may be revived by mutual consent and in such event the Revival premium should be paid to Us within 15 days of the installment due date. Wherever Premiums are not received within the revival period, the Policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the policy. However, We will be liable to pay in respect of all claims where the treatment/admission has commenced before date of termination of such policies.

Renewal Terms:

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

Where We have discontinued or withdrawn this product/plan or where You will not be eligible to renew as You have moved out of the Group, You will have the option to renew under the nearest substitute Policy being issued by Us, provided Benefits payable shall be subject to the terms contained in such other policy which has been approved by the IRDAI.

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

F.II.17. Our Right of Termination

Prior to the termination of the Policy at the expiry of the Policy Period shown in the Policy Schedule, cover will end immediately for all Insured Persons, if:

- if You do not pay the Premiums owed under the Policy within the Grace Period
- For Non-Indian Nationals returning to their country of domicile member will be eligible for coverage under the applicable Policy for coverage until the end of the Policy or earlier if specifically terminated by the employer

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If treatment has been authorised or a cashless approval has been issued, We will not be held responsible for any treatment costs if the Policy ends or an employee/member or Dependent leaves group or if the policy is no longer in force, before treatment has taken place. However, We will be liable to pay in respect of all claims where the treatment/admission has commenced before date of termination of such policy.

Termination for Insured Person's cover

a. On Immediate basis

Cover will end for an Employee/ member

- If the Insured Person dies. You may agree to continue cover for his/ her Dependents up to the next Annual Renewal Date when their cover under this Benefit will end
- If the Insured Person ceases to be a member of the group.
- If We stop receiving Premiums for Insured Person and his/her Dependents (if any)
- When this Policy terminates at the expiry of the Policy Period shown in the Policy Schedule

Cover will end for a Dependent

- If he or she dies
- When he or she ceases to be a Dependent;
- If the Insured Person ceases to be a member of the group.

b. At the next Annual Renewal Date

Cover will end for spouse or any unmarried partners

- If an employee/member gets divorced or the unmarried partners no longer live together or a civil/contractual partnership is dissolved, then the spouse or unmarried, civil/contractual partner will no longer be considered as a Dependent for the purposes of this Policy.

Cover will end for the spouse or unmarried, civil/contractual partner

- Cover for the spouse or unmarried, civil/contractual partner ends as soon as the final decree/final dissolution order has been granted.

F.II.18. Special Provisions

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

It is further clarified that if any special condition is stipulated in the Policy Schedule and/or Certificate of Insurance, then such special condition shall have effect accordingly.

The special provision shall be within the purview of the Policy Terms and Conditions.

F.II.19. Limitation of Liability

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

F.II.20. Endorsements

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

a) Non-Financial Endorsements-which do not affect the premium.
Rectification in name of the proposer/policyholder/Insured Person.
Rectification in gender of the proposer/policyholder/Insured Person.

Rectification in relationship of the Insured Person with the proposer/ policyholder.
Rectification of date of birth of the Insured Person (if this does not impact the premium).
Change in the correspondence address of the proposer/policyholder/ Insured Person.
Change/updation in the contact details viz., phone number, E-mail ID, etc.
Updation of alternate contact address of the proposer/policyholder/ Insured Person.
Change in Nominee details.
Addition/Deletion/updation of GSTIN
Change in occupation (if this does not impact the premium)
Change/ rectification in Account number
Change of Policyholder
b) Financial Endorsements-which result in alteration in premium
Deletion of Insured Person on death if no claims are paid/outstanding.
Deletion of Insured Person
Rectification of date of birth of the Insured Person.
Addition of member (New Born Baby/Newly wedded spouse/partner)
Addition of member
Change in the correspondence address of the Proposer/Policyholder/ Insured Person.
Rectification in gender of the Proposer/Policyholder/Insured Person.
Change of Policyholder
Change in occupation

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

F.II.21. Electronic Transactions

The Insured Person agrees to adhere to the terms and conditions and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of Us for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.

These terms and conditions shall be within the approved Policy Terms and Conditions.

However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI (Protection of Policyholders Interests) Regulations 2017, as may be amended from time to time. All conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form, all necessary disclosures on terms, conditions and major exclusions shall be made known to the Insured Person.

F.II.22. Communications & Notices

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

a. You/Insured Person, at the address as specified in Policy Schedule/ Certificate of Insurance.

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

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

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

F.II.23. Anti-Corruption

Notwithstanding any provision in this Policy or otherwise, it is agreed that We shall have no liability or obligation where We reasonably believe such would violate any applicable law, regulation or order, including but not limited to, anti-corruption laws and programs imposing financial sanctions on targeted individuals, entities, or nations, including (without limitation) any relevant (1) resolution of the United Nations Security Council and/ or any implementation thereof in any jurisdiction, (2) law, regulation, and/or order administered by the Department of Treasury of the United States of America, and/or (3) regulation issued by the European Council and/or any implementation thereof in any jurisdiction. We shall have no liability or obligation and this Policy shall, at Our election, be deemed void where any actions in furtherance of the Policy is prohibited. Furthermore, We are under no obligation to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws. Furthermore, We shall not pay claims for services received in sanctioned countries if doing so would violate the requirements of the United States Department of Treasury's Office of Foreign Assets Control, or the United Nations Security Council Sanctions Committees.

G. Other terms and conditions

G.I. Claims procedure

G.I.1. Condition Precedent

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

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

Processing of claims for Cashless facility and/or for reimbursement and providing access to the Network Provider will be through Our Service Partners. Details of the Service Partners will be available on the health card issued by Us to the Insured Persons as well as on Our website. The Service Partners provide access to domestic as well as global Network Providers and will facilitate claims for Cashless Facilities. The Service Partner may also support Us in assessing of reimbursement claims. In India the claims will be serviced by an approved Third Party Administrator (TPA) while all Claims outside of India will be managed by a wholly owned non-insurance Cigna Corporation subsidiary and/ or a Service Provider that provides such services.

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

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

The updated applicable list of Network Providers is available on Our website. Details of applicable Network Providers may also be obtained from Our call centre or contacting Our Service Partner. In advance of availing Cashless facilities from a Network Provider, the updated list may be checked to ensure that the Network Provider can provide a Cashless facility in respect of the treatment required for the Insured Person.

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

(a) Forthwith intimate, file and submit the Claim in accordance to the Claim Procedure defined under Section G.I.3, G.I.4 & G.I.5., as mentioned below.

(b) Follow the directions advice or guidance provided by a Medical Practitioner.

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

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

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

G.I.3. Claim Intimation

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

In the case of Planned Hospitalization - The Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.

In the case of Emergency Hospitalization - The Insured Person will intimate such admission within 24 hours of such admission but not later than discharge from the Hospital.

The following details are to be provided to Us/ Our TPA/ Our Service Partner at the time of intimation of Claim:

i) Policy Number

ii) Name of the Policyholder

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

iv) Nature of Illness/Injury

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

vi) Date of Admission

vii) Any other information as requested by Us

G.I.4. Cashless Process

Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider, Network Hospital or Common empanelment of hospital/ healthcare for Illness/Injury or any other contingency that is covered under the Policy.

For all Cashless Facility pre-authorizations, Insured Person will, in any event, be required to settle all non-admissible expenses, expenses towards sub-limit, Co-Payment and/or Deductibles (if applicable), directly with the Hospital/Network Provider.

Conditions -

- Cashless facility is available only at Our Network Providers, Network Hospital or Common empanelment of hospital/healthcare.
- For availing Cashless facility, the Insured Person must present the health card as provided by Us, along with a valid photo identification proof Member ID/Voter ID card/Driving License/Passport/PAN Card/ any other identity proof as approved by Us).

i. For Planned Hospitalization:

The Insured Person should approach the Network provider at least 48 hrs prior to the admission for Hospitalization.

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

Upon receiving the pre-authorization form and all related medical information from the Network Provider or common empanelment of hospital/healthcare providers, we will verify the eligibility of cover under the Policy.

Wherever the information provided in the request is sufficient to ascertain the authorization We shall issue the authorization Letter to the Network Provider or common empanelment of hospital/healthcare providers. Wherever additional information or documents are required We will call for the same from the Network provider or common empanelment of hospital/healthcare providers and upon satisfactory receipt of last necessary documents the authorization will be issued. All authorizations will be issued within a period of 1 hours from the receipt of last complete documents.

.The Authorization letter will include details of Amount Sanctioned, any specific limitation on the claim, any applicable sub-limits, Co-pays or Deductibles and non-payable items if applicable.

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

Discharge Process:

At the time of discharge:

i. The Network Provider or hospital/healthcare providers of common empanelment may forward a final request for authorization for any residual amount to us along with the discharge summary and the billing format in accordance with the process described at G.I.4.(a) above.

ii. We shall accept or decline such additional expenses within 3 (Three) hours of receiving the complete documents for final discharge from Network provider or Common empanelment of hospital/healthcare providers.

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

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

ii. In case of Emergency Hospitalization

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

b. The Network Provider shall forward the request for authorization within 24 hours of admission to the Hospital as per the process under G.I.4 i. but not later than actual discharge from the Hospital.

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

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

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

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

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

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

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

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 at Section G.I.4.i. above.

At the time of discharge:

The Network Provider may forward a final request for authorization for any residual amount to Us along with the Insured Person's discharge summary and the billing format in accordance with the process described at Section G.I.4.i. above.

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

Cashless facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider for Illness or Injury as the case may be which are covered under the Policy. For all cashless authorizations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits, Co-Payments and Deductible (if applicable), directly with the Hospital.

Submission of Claim Documents:

The Network Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly

to us. The following claim documents should be submitted to us within 15 days from the date of discharge from Hospital -

a. Claim Form Duly Filled and Signed
b. Original pre-authorization request
c. Copy of pre-authorization approval letter (s)
d. Copy of Photo ID of Patient Verified by the Hospital
e. Original copy of consultations
f. Original discharge/death summary;
g. Operation theatre notes (if any);
h. Original Hospital main bill and break-up of the bill;
i. Original investigation reports, X Ray, MRI, CT Films and HPE;
j. Medical Practitioner's reference slips for investigations/pharmacy;
k. Original pharmacy bills, prescriptions, and invoices;
l. MLC/FIR report/post mortem report (if conducted).
m. Bills from registered service provider (Ambulance Cover)

The Documents listed above will apply for claims in India, however for claims arising due to Hospitalization of the Insured Person outside of India the requirements may vary based on the applicable agreements between the Service Partner and the Network Provider and any applicable provisions of local laws, regulations or rules.

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 Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to Us which will be considered subject to the Policy Terms and Conditions.

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

G.I.5. Claim Reimbursement Process

a. Collection of Claim Documents

Wherever Insured Person has opted for a reimbursement of expenses, he/she may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense not later than 90 days from the date of discharge from the Hospital. The Insured Person can obtain a claim form from any of Our branch offices or download a copy from Our website: www.manipalcigna.com.

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

We may call for any additional documents/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity Our branch offices shall give due acknowledgement of collected documents to the Insured Person.

b. If the submission of claim documents as specified in Section G.I.5 a. above is delayed, then in addition to the documents mentioned above, reasons for such delay shall also be provided to Us in writing. We will condone delay on merit for delayed claims where the delay has been proved to be for reasons beyond Insured Person's control.

Documents listed above will apply for claims in India, however for claims outside of India, the requirements may be subject to variation based on Our existing agreements, local market practice and provisions of applicable law.

G.I.6. Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents, and notify the relevant stakeholders (such as Network Provider or Common empanelment of hospital/healthcare providers) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.
b. We shall settle the claim payable amount after scrutinizing the claim documents.
c. In case a reimbursement claim is received when a Pre-Authorization letter has been issued, before approving such claim a check will be made with the provider whether the Pre-authorization has been utilized as well as whether the Policyholder has settled all the dues with the provider. Once such check and declaration is received from the Provider, the case will be processed.

G.I.7. Claim Assessment

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

i. If the provisions of the Contribution Clause apply, Our liability to make payment under the claim shall be first apportioned accordingly.
ii. Where a room accommodation is opted for higher than the eligible room category under the plan, only the Room Rent for the applicable accommodation will be apportioned.
iii. Subsequent to applying Section G.I.7 (i) and (ii) to the admissible claim amount, the following cost sharing mechanisms will be applied sequentially if applicable -
iv. Deductible or Co-pay (if applicable)
v. At any given stage if the Insured Person's total cost sharing amount under Deductible, Co-pay (if applicable) under Section G.I.7 (iii) above is equal to the opted 'Maximum limit on Out of Pocket' limit, no further deductions will apply subject to the Sum Insured available for specific Benefits (if applicable) and in any case not greater than the Sum Insured available under the Plan.

Claim Assessment for Benefit Plans:

We will pay fixed benefit amounts where available under the Base Benefits and the Optional Benefits as specified in the Policy Schedule/Certificate in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts other than the ones specified in the Policy

G.I.8. Re-opening of Claim

We may allow a closed claim to be reopened depending on the validity and the circumstances of the claim.

G.I.9. Claims Investigation

We may, at Our discretion, depending upon the facts of the case, investigate and determine the validity of claims. Such investigation shall be conducted on case to case basis and will be concluded accordingly. Any verification or investigation will be carried out by individuals or entities authorized by Us, and the cost of such verification/ investigation will be borne by Us.

G.I.10. Pre-hospitalization Medical Expenses Cover and Post-hospitalization Medical Expenses Cover claims

The Insured Person, if opted for, should submit the Post-hospitalization Medical Expenses Cover claim documents at his/her own expense within 15 days of completion of Post-hospitalisation Treatment or period, or eligible Post-Hospitalization period of cover, whichever is earlier.

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

G.I.11. Representation against Rejection

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

G.I.12. Claims falling in 2 policy periods

If a Hospitalization claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles & Co-pays for each Policy Period subject to limit of Sum Insured provided that You have renewed the Policy with Us for the subsequent year.

G.I.13. Payment Terms

a. The Sum Insured opted by the Insured Person 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.

b. If the 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 claims within India.

c. For Cashless Claims, the payment shall be made to the Network Provider or common empanelment of hospital/healthcare providers where discharge shall be treated as full and final discharge of Our liability under the Policy.

d. For Reimbursement Claims, the payment will be made to You/the Insured Person. In the unfortunate event of an Insured Persons 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 Our liability under the Policy.

G.I.14. Wellness, Dental & Vision Benefit Claim

The Insured Person shall avail these Benefits as defined in 'Policy Terms and Conditions for Optional Covers', under Section I. 23, 24 & 25, if opted for.

a) Submission of claim

Insured Person can send the Wellness Benefit claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to Our branch office or head office.

b) Assessment of Claim Documents

We shall assess the claim documents and ascertain the admissibility of claim.

c) Settlement & Repudiation of a claim

We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.

d) In respect of orthodontic claims for children below 18 years, pre-authorization is a must.

For Claims in respect of orthodontic treatment towards dependent children below 18 years of Age, the member or dependent must send the following information prepared by the dentist who is to carry out the proposed treatment to Us before treatment starts, so that We can confirm the Benefit that will be payable.

- a full description of the proposed treatment;
- X-rays and study models;
- an estimate of the cost of the treatment.

Payments under this Benefit will be payable only if We have authorised such payment before the respective treatment commences.

G.I.15. Emergency evacuation & Medical repatriation -

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

b) Emergency medical evacuations shall be pre-authorized by Us

c) Our team of Specialists in association with the Service Provider shall determine the Medical Necessity of such Emergency evacuation or medical repatriation post which the same will be approved.

G.I.16. Health Appliances Cover

In an event of an Insured Person being prescribed a health appliance for medical purpose by a Medical Practitioner, he/she can send the claim request 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. We may call for any additional documents/information as required based on the circumstances of the claim.

All claims under this Benefit will be payable only if it is pre-authorised by Us

G.I.17. Deductible

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

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

b. Wherever such Hospitalization claims as stated under Section G.I.4.(i) above is being covered under another Policy held by You, We will assess the claim on available photocopies duly attested by Your Insurer/TPA as the case may be.

G.I.18. Area of Cover

The Policy provides the following options for the applicable Area/s of Cover. The Policy Schedule/Certificate of Insurance will specify the Area of Cover option that is in force for the group. We will indemnify the Medical Expenses incurred in the applicable Area of Cover for the listed Benefits in respect of the Insured Person.

1. South Asia (Indian Sub-continent), Asian Middle East, African countries
2. Asia Pacific excluding Hong Kong, Singapore
3. Asia Pacific including Hong Kong, Singapore
4. India, Europe, Canada, Latin America and Caribbean island countries
5. Worldwide excluding United States
6. Worldwide including United States

For a specific group, the Area of Cover may be limited to any particular

country or region which is a part of any one or a part of combination of above list of Area of Covers.

G.I.19. Co-pay

The Co-pay will apply to all indemnity claims made under the Base Covers as well as Optional Covers available under the Policy. If the Co-pay is in force, We will be liable to pay only the difference percentage of the admissible claim amount that We assess for the payment in respect of the Policy and the balance opted Co-pay percentage shall be borne by the Insured Person.

The Policy Schedule/Certificate of Insurance will specify the applicable Co-pay under Base and/ or Optional Covers.

Wherever Co-pay is opted under any Optional Cover, the opted percentage of Co-pay shall be applicable for the Optional Cover and the Co-pay opted under the Base Cover shall not be applicable for such Cover.

G.I.20. Deductible

The Deductible will apply to all indemnity claims, made under Base as well as Optional Covers. If the Deductible is in force, We will be liable to pay only the difference amount of the admissible claim amount that We assess for the payment in respect of the Policy and the balance opted Deductible amount shall be borne by the Insured Person.

The Policy Schedule/Certificate of Insurance will specify the applicable Deductible under Base and/or Optional Covers.

Wherever Deductible is opted under any Optional Cover, the opted amount of Deductible shall be applicable for the Optional Cover and the Deductible opted under the Base shall not be applicable for such Cover.

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

G. I. 21.Application of Multiple policies clause

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

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

i) Cashless hospitalization: If the Insured Person avails cashless facility for hospitalization, the Insured, Network Provider, or common empanelment of hospital/healthcare provider will intimate us of the admission through a pre-authorization request with all details and estimated amount for the hospitalization. The Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies.

ii) Reimbursement claim: If the Insured Person is admitted and pays the entire bill, then files for a reimbursement claim, they must inform us 48 hours before admission for planned admission or within 24 hours post hospitalization for emergencies, but no later than discharge. Post discharge, the Insured will send all original documents, bills, and claims forms to one Insure rand certificate copies of all documents to the others

b) Retail policy & group policy from the Company:

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

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

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

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

G.II.Annexure – I:
Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:- bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.:- 0755-2769201/202 Email:- bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@cioins.co.in	State of Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:- bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana, (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24333678 Fax:- 044-24333664 Email:- bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011 – 23237539 Email:- bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Email:- bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Territory of Puducherry.

JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email:- bimalokpal.jaipur@cioins.co.in	State of Rajasthan.
KOCHI Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759/9338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@cioins.co.in	States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. TEL : 033 - 22124339 / 22124341 Email:- bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim, and Union Territories of Andaman and Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522 - 4002082 / 3500613 Email:- bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022 - 69038800/27/29/31/32/33 Fax:- 022-26106052 Email:- bimalokpal.mumbai@cioins.co.in	State of Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai and Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukkabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	States of Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	States of Maharashtra, Areas of Navi Mumbai and Thane but excluding Mumbai Metropolitan.

G.III Annexure- II - Non Medical Expenses

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

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

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