MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY

Policy Contract

B Preamble

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

C Definitions

C.I Standard Definitions

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

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

3. **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.

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

5. **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 installment premium due is not paid on or before the premium renewal date or grace period.

6. **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.

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

8. **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.

9. **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.

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

11. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
    i) has qualified nursing staff under its employment;
    ii) has qualified medical practitioner/s in charge;
    iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv) maintains daily records of patients and will make these accessible to the insurance company's authorised personnel.

12. **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.

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

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

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

15. **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.

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

17. **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.

18. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received. 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.

19. **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.

20. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as

a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;

ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii) has qualified medical practitioner(s) in charge round the clock;

iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;

v) maintains daily records of patients and makes these accessible to the insurance company's authorised personnel.

21. **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.

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

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

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

(i) it needs on going or long-term monitoring through consultations, examinations, check-ups, and/ or tests

(ii) it needs on going or long-term control or relief of symptoms

(iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

(iv) it continues indefinitely

(v) it recurs or is likely to recur

23. **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.

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

25. **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.

26. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

27. **Maternity expenses means:**

a) medical treatment expenses traceable to child birth (including complicated deliveries and caesarean sections incurred during hospitalization);

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

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

29. **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.

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

and jurisdiction of license.

31. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i) is required for the medical management of the illness or injury suffered by the insured;
    ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii) must have been prescribed by a medical practitioner;
    iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

32. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

33. **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.

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

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

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

37. **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.

38. **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.

39. **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.

40. **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.

41. **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.

42. **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.

43. **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.

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

45. **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.

46. **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.)

47. **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.

48. **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.

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

C.II Specific Definitions

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

2. **Annual Renewal Date** means the anniversary of the Inception Date each year or any other date which We and the Policyholder may agree in writing.

3. **Non-Allopathic Treatments** are forms of Treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha, Homeopathy and Naturopathy in the Indian context.

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

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

6. **Associated Medical Expenses** shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anesthetist/ Specialist excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

20. **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.

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

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

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

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

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

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

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

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

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

29. **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.

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

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

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

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

contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.

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

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

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

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

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

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

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

40. **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).

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

42. **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.

43. **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.

44. **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.

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

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

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

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

D Benefits under the Policy

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

D.I. Base Covers

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

D.I.1. In-patient Hospitalization Expenses Cover

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

i. Room charges up to the category/limit specified in the Policy Schedule/Certificate Of Insurance,
ii. Charges for accommodation in ICU/CCU/HDU,
iii. Operation theatre cost,
iv. Medical Practitioner fees,
v. Specialist fee,
vi. Surgeon's fee,
vii. Anaesthetist fee,
viii. Radiologist fee,
ix. Pathologist fee,
x. Assistant Surgeon fee,
xi. Qualified Nurses fee,
xii. Medication,
xiii. Cost of diagnostic tests as an In-patient such as but not limited to Radiology, Pathology tests, X-rays, MRI and CT Scans, Physiotherapy and Drugs, consumables, blood, oxygen.
xiv. Surgical Appliance and/or Medical Appliance.

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 Hospitalization Expenses and the necessity being certified by an authorised 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.

Medical Expenses related to any admission (under In-patient Hospitalization, Day Care Treatment or Domiciliary Hospitalization) primarily for enteral feedings will be covered, up to 15 days in a Policy Year, or as otherwise specified in the Policy Schedule/Certificate of Insurance, provided it is Medically Necessary and is prescribed by a 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.

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

If the Insured Person is admitted in a room where the room category or the Room Rent incurred is higher than that which is specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred.

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

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

D.I.2. Day Care Treatment Cover

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

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

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

D.I.3. Pre-hospitalization Medical Expenses Cover

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

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

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

D.I.4. Post-hospitalization Medical Expenses Cover

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

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

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

D.I.5. Road Ambulance Cover

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

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

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

D.I.6. Domiciliary Hospitalization Cover

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

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

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

c) Pre-hospitalization and Post Hospitalization Medical Expenses will be payable up to the specified number of days in accordance with Section D.I.3 above.

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

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

D.I.7. Donor Expenses Cover

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

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

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

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

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

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

ii. Cost towards donor screening;

iii. Cost associated to the acquisition of the organ;

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

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

There are Optional covers available with the Policy. Refer Policy Contract annexed herewith for Optional Covers.

E Exclusions

PERMANENT EXCLUSIONS & WAITING PERIODS

All the Waiting Periods shall be applicable individually for each 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, relating to or howsoever attributable to any of the following, unless specified otherwise:

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. Specific 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:

a) Cataract,

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

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

d) Varicose Veins and Varicose Ulcers,

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

f) Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

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

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.

Initial waiting period applicable under the policy will be 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);

iii. greater than or equal to 40 or

iv. 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

b. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
c. 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. Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way, unless specifically covered under the policy.

E.II.2. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

E.II.3. 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.

E.II.4. External Congenital Anomaly or any complications or conditions arising therefrom.

E.II.5. Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness/Injury for which the Insured Person was Hospitalised.

E.II.6. Any stay in Hospital without undertaking any Treatment or any other purpose other than for receiving eligible Treatment of a type that normally requires a stay in the Hospital.

E.II.7. Treatment received outside India.

E.II.8. Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.

E.II.9. 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.10. 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.11. 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.12. For complete list of non-medical expenses, please refer to the Annexure II - List I "Non-Medical Expenses" and also on Our website. Any opted Deductible (Per claim/ Aggregate/Corporate) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule/Certificate Of Insurance to this Policy.

E.II.13. 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. Disclosure of Information

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

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

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

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

i. The Company shall settle or reject the claim, as the case may be, within 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 Person(s) 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 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 by You

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, non-disclosure or misrepresentation by the insured person.

i. The Company shall 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, 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

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

F.I.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. Premium Payment in Instalments (For Policies other than 'Single/Yearly' Premium payment modes)

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

- Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.
- If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" Sections in the event of payment of premium within the stipulated grace Period.
- No interest will be charged If the instalment premium is not paid on due date.
- In case of instalment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- Instalment facility shall not be available for the Policy Tenure more than 1 year.

F.I.14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, 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.15. 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.16. 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:/ www.cioins.co.in/ Ombudsman.

F.I.17. 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. Reasonable Care

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

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 Policyholder only.

F.II.3. Material Information for administration

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

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

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

F.II.4. Material Change

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

F.II.5. Eligibility

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

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

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

F.II.6. Geography

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

F.II.7. 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.8. Premium

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

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, 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.9. Parties to the Policy

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

F.II.10. Currency

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

F.II.11. Addition and Deletion of a Member

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

(a) Additions

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

(b) Deletions

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

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

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

F.II.12. No Constructive Notice

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

F.II.13. 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.

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

b) Financial Endorsements - which result in alteration in premium

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

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

F.II.14. 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.

F.II.15. Records to be maintained

You or the Insured Person, as the case may be, shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person, as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Year

and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

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.

For Contributory Policy

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

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

Renewal of Policy

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

vi. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
vii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
viii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
ix. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30/15, as applicable, days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
x. 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.

F.II.17. Our Right of Termination

Termination of Policy:

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

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

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

Termination for Insured Person's cover

Cover will end for a Member or dependent:

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

F.II.18. 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.19. Underwriting Loadings & Discounts

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

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

c. We shall inform You about the applicable risk loading or Special Condition through a counter offer letter or through an electronic mode, as the case may be and You would be required to respond with Your consent within the duration specified in the counter offer.

F.II.20. 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.21. Electronic Transactions

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

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

F.II.22. Communications & Notices

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

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

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

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

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

F.II.23. COVER TYPE

The Policy provides cover on an Individual or Family Floater basis. Under Individual basis, each Insured Person has a separate Sum Insured. Under Family Floater basis, the Sum Insured limit is shared by the

whole family of the group member as specified in the Policy Schedule/Certificate Of Insurance and Our total liability for the family cannot exceed the Sum Insured in a Policy Year. The cover type basis shall be as specified in the Policy Schedule/Certificate Of Insurance. The basis of cover chosen for the Base Cover is applicable for the Optional Covers as well.

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

G. Other terms and conditions

G.I. Claims Procedure

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

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

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

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

G.I.1. Condition Precedent

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

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

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

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

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

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

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

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

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

(d) Allow the Medical Practitioner or any of Our representatives to inspect the medical and 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 either at the call centre or in writing 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.

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

i) Policy Number
ii) Name of the Policyholder
iii) Name of the Insured Person in whose relation the claim is being lodged
iv) Nature of Illness/Injury/Accident/Critical Illness
v) Name and address of the attending Medical Practitioner and Hospital
vi) Date of admission
vii) Any other information as requested by Us

G.I.4. Cashless Process

Cashless facility is available only at our Network Hospital or Common empanelment of hospital/ healthcare providers as specified by Insurance Council. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital or Common empanelment of hospital/ healthcare providers as specified by Insurance Council.

Pre-Authorisation Process

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

(a) For Planned Hospitalization:

i. The Insured Person shall at least 48 hours prior to admission to the Hospital approach the Network Provider for Hospitalization for undergoing medical Treatment.
ii. 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.
iii. 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.
iv. 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.
v. The authorisation letter will include details of sanctioned amount, diagnosis, and date of approval.
vi. The authorization letter shall be valid only for a period of 15 days from the date of issuance of authorization.

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

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

(ii) We shall accept or decline such additional expenses within 1 (One) hour of receiving the request for enhancement from You.

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

At the time of discharge:

(i) The Network Provider or common empanelment of hospital/healthcare providers 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.

(b) In case of Emergency Hospitalization

(i) The Insured Person may approach the Network Provider or common empanelment of hospital/

healthcare providers for Hospitalization for medical treatment.

(ii) The Network Provider or common empanelment of hospital/healthcare providers shall forward the request for authorization within 24 hoursof admission to the Hospital as per the process under Section G.I.4 (a).

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

(iv) In the interim, the Network Provider or 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.

(v) The Network Provider or common empanelment of hospital/healthcare providers shall refund the deposit amount to You barring a token amount to take care of non-covered expenses once the pre-authorization is issued.

Note: Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital or common empanelment of hospital/ healthcare providers for Illness or Injury which are covered under the Policy and shall not be available to the Insured Person for coverage under Daily Cash for Shared Accommodation (Section D.1.10), For all Cashless authorizations, You will, in any event, be required to settle all non-admissible expenses, Co-payment and / or Deductibles (if applicable), directly with the Hospital.

The Network Provider or common empanelment of hospital/healthcare providers will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to us.

The following claim documents should be submitted to Us within 15 days from the date of discharge from Hospital –

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

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

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

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

Enhancement to Pre-Authorised Amount:

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

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

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

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

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

Submission of Claim Documents:

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

- Claim Form duly filled and signed
- Original pre-authorisation request
- Copy of pre-authorisation approval letter (s)
- Copy of photo ID of Insured Person verified by the Hospital
- Original discharge/death summary
- Operation theatre notes(if applicable)
- Original Hospital main bill and break up bill
- Original investigation reports, X Ray, MRI, CT Films, HPE
- Medical Practitioner's reference slips for investigations/pharmacy
- Original pharmacy bills
- MLC/FIR report/post mortem report (if applicable and conducted)
- Cancelled check for NEFT payment.
- Payment receipt.

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

G.I.5. Claim Reimbursement Process

(a) Collection of Claim Documents for indemnity based covers

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

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

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

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

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

G.I.6. Scrutiny of Claim Documents

(i) 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.

(ii) We shall settle the claim payable amount after scrutinizing the claim documents.

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

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

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

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

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

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

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

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

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

ii) Sum Insured

iii) Cumulative Bonus (if applicable)

iv) Restored Sum Insured (if applicable)

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

Claim Assessment for Benefit Plans:

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

G.I.8. 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.9. Pre-hospitalization Medical Expenses Cover and Post-hospitalization Medical Expenses Cover claims

The Insured Person should submit the Post-hospitalization Medical Expenses Cover claim documents at his/her own expense within 15 days of completion of Post-hospitalization 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.10. 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.11. Claim Payment Terms

- We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
- All claims will be payable in India and in Indian rupees.
- We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimised the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.
- The Sum Insured opted under the Policy shall be reduced by the amount payable/paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.
- If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

For Cashless claims, the payment shall be made to the Network Provider or common empanelment of hospital/healthcare providers whose discharge would be complete and final.

For Reimbursement claims, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, We will pay the Nominee (as named in the Policy Schedule/ Certificate Of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

G. I. 12. 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, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY
LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1.	BABY CHARGES (UNLESS SPECIFIED/ INDICATED
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU.DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE

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

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

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

G.IV.Annexure III- List of TPAs