MANIPALCIGNA PROHEALTH SELECT

Policy Contract

B. PREAMBLE

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

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

C. Definitions

C.I Standard Definitions

1. **Accident** means a 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 the treatment was taken.

3. **AYUSH treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

4. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment 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.

5. **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.

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

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

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

9. **Cumulative Bonus**

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

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

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

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

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

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

14. **Disclosure to Information Norm** means 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.

15. **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:
    i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.

16. **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.

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

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

19. **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.

20. **Illness** means sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a) **Acute condition -** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b) **Chronic condition -** A chronic condition is defined as a disease, illness or injury that has one or more of the following characteristics:
    - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
    - it needs on-going or long term control or relief of symptoms
    - it requires your rehabilitation or for you to be specially trained to cope with it
    - it continues indefinitely
    - it recurs or is likely to recur

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

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

23. **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.

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

25. **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.

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

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

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

29. **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.

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

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

32. **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.

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

34. **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 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.

35. **Pre-existing Disease** 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, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

36. **Pre-hospitalization Medical Expenses** are Medical Expenses incurred during pre-defined number of days immediately before the Insured Person is Hospitalised, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

38. **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.

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

40. **Room Rent** Room Rent shall mean the amount charged by a hospital towards Room and Boarding expenses and shall include associated medical expenses.

41. **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.

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

C.II. Specific Definitions

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

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

3. **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.

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

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

6. **Covered Relationships shall include** spouse, children, brother and sister of the Policyholder who are children of same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, Uncle, Aunt, Niece and Nephew.

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

8. **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.

9. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Inception Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period.

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

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

12. **Insured Person** means the person (s) named in the Schedule to this Policy, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

13. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy Contract and shall be read together.

14. **Policy Period** means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.

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

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

17. **Restored Sum Insured** means the amount restored in accordance with Section D.I.8 of this Policy

18. **Schedule** means schedule issued by Us, attached to and forming part of this Policy mentioning the details of the Policy Holder, Insured Persons, Sum Insured, Policy Period, Premium Paid (including taxes) and if more than one, then the latest in time.

19. **Single Private Room** means a single Hospital room of any rating with / without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. This excludes a suite.

20. **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.

21. **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the amount representing Our maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of that Insured Person.
    i. In case where the Policy Period for 2/3 years, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits up to the full Sum Insured as opted will be available for the second/third year.
    ii. In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

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

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

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

D . BENEFITS UNDER THE POLICY

D.I BASIC COVERS

D.I.1. Inpatient Hospitalization:

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

a. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to eligible Room Category or eligible Room Rent as per the Policy and specified in the Schedule to this Policy.
b. Intensive Care Unit charges for accommodation in ICU,
c. Operation theatre charges,
d. Fees of Medical Practitioner/ Surgeon,
e. Anaesthetist,
f. Qualified Nurses,
g. Specialists,
h. Cost of diagnostic tests,
I. Medicines,
j. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure.

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 Modern and Advanced Treatment methods will be covered when availed under In-patient Hospitalization or as a Day Care Treatment (Section D.I.4):

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty

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

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 provided it is Medically Necessary and is prescribed by a Medical Practitioner.

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

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

The cover is available subject to below conditions:

i. The purpose of Hospitalization is to avail Medically Necessary Treatment.
ii. The necessity of the Hospitalization is certified by an authorised Medical Practitioner.
iii. For conditions other than STD, the Insured Person should be a declared HIV positive.
iv. This cover is available after a Waiting Period of 2 years from the inception of the Policy with Us, with respect to the Insured Person.
v. We will pay for Pre-hospitalization and Post-hospitalization medical expenses maximum up to 30 days each.
vi. Benefit under this cover is payable maximum up to the Sum Insured with a maximum limit of Rs. 5 Lacs and any claim under this section will reduce the Sum Insured.

In addition to the Policy exclusions, following additional exclusions shall be applicable:

a. Chronic health conditions including ischemic heart disease, chronic liver disease, chronic kidney disease, cerebro - vascular disease/ stroke Chronic obstructive lung diseases, joint disorders and neoplasms which are not directly related to the patient's immunity status would not be covered under this benefit.
b. Lifestyle diseases like diabetes, hypertension, heart diseases and dyslipidaemia which are not related to HIV / AIDS or STD would not be covered under HIV/AIDS or STD limit.

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 Schedule to this Policy, 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.

For the purpose of this Section "Associated Medical Expenses" shall include - Room Rent, Nursing Charges, Operation Theatre Charges, Fees of Medical Practitioner/Surgeon/ Anesthetist/ Specialist excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalization in ICU.

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

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

D.I.2. Pre - hospitalization:

We will, on a reimbursement basis cover Medical Expenses of an Insured Person which are incurred due to a Disease/ Illness or Injury up to 60 days immediately prior to the Insured Person's date of Hospitalization up to limits specified in the Schedule, provided that a Claim has been admitted under In-patient Benefit under Section D.I.1 and is related to the same illness/condition.

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

D.I.3. Post - hospitalization:

We will, on a reimbursement basis cover Medical Expenses of an Insured Person which are incurred due to a Disease/ Illness or Injury up to 90 days immediately post discharge of the Insured Person from the Hospital up to limits specified in the Schedule, provided that a Claim has been admitted under In-patient Benefit under Section D.I.1 and is related to the same illness/condition.

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

D.I.4. Day Care Treatment:

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

Coverage will also include pre/post-hospitalization expenses as available under the Policy.

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

D.I.5. Domiciliary Treatment:

We will cover Medical Expenses of an Insured Person which are towards a Disease/Illness or Injury which in the normal course would have required Hospitalization but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a Hospital transfer; or
ii. A Hospital bed was unavailable;

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

(a) We will however pay for Pre-Hospitalization and Post-Hospitalization Medical Expenses up to 30 days each in accordance with Section D.I.2 above.
(b) We shall not be liable under this Policy for any Claim in connection with or in respect of the following:
    i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
    ii. Arthritis, gout and rheumatism,
    iii. Chronic nephritis and nephritic syndrome,
    iv. Diarrhoea and all type of dysenteries, including gastroenteritis,
    v. Diabetes mellitus and Insipidus,
    vi. Epilepsy,
    vii. Hypertension,
    viii. Pyrexia of unknown origin.
    ix. Any use of artificial life maintenance including life support machine use.

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

D.I.6. Ambulance Cover:

a. We will provide for reimbursement of Reasonable and Customary expenses up to Rs. 2000 per hospitalization event as specified in the Policy Schedule, towards transportation of an Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury in case of an Emergency, necessitating the Insured Person's admission to the Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

b. Reasonable and Customary expenses shall include:

(i) Costs towards transferring the Insured Person from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital; or

(ii) When the Insured Person requires to be moved to a better Hospital facility due to lack of super speciality treatment in the existing Hospital.

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

D.I.7. Donor Expenses:

a. We will cover In-patient Hospitalization Medical Expenses towards the donor (in accordance with Section D.I.1 above) for harvesting the organ up to the limits of the Sum Insured, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that -

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

c. We have admitted a claim under Section D.I.1 - towards In-patient Hospitalization

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

i. Any Pre or Post - hospitalization Medical Expenses,

ii. Cost towards donor screening,

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

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

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

D.I.8. Restoration of Sum Insured:

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

(a) The total of the opted Sum Insured and earned Cumulative Bonus (or Cumulative Bonus Booster if opted) is insufficient as a result of previous claims in that Policy Year.

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

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

(d) The Restored Sum Insured will not be considered while calculating the Cumulative Bonus or Cumulative Bonus Booster (if opted).

(e) Such restoration of Sum Insured will be available only once during a Policy Year to each insured in case of an individual Policy and can be utilised by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

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

(g) If the Restored Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

For any single claim during a Policy Year the maximum Claim amount payable shall be sum of:

i. The Sum Insured

ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)

(h) During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:

i. The Sum Insured

ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)

iii. Restored Sum Insured

Restoration of Sum Insured shall not apply to Worldwide Emergency Cover and for Rs 0.5 & 1 Lac Sum Insured under ProHealth Select (A).

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

D.I. 9. AYUSH Cover

We will cover In-patient medical expenses up to the limits of Sum Insured, for an Insured Person towards non- allopathic treatments such as Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy for Hospitalization arising due to Accident or Illness provided such Hospitalization is for more than 24 hours and undertaken in a AYUSH hospital, where an AYUSH Hospital is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner (s) comprising any of the following:

i) Central or State Government AYUSH Hospital; or

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

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

a) Having at least five in-patient beds;

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

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

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

The following exclusions will apply in addition to the exclusions under section E:

- Facilities & services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation etc.
- Any treatment outside India.

D.II. VALUE ADDED COVERS

D.II.1. Cumulative Bonus

We will increase Your Sum Insured by 5% at the end of the Policy Year if the Policy is renewed with Us provided that there are no claims paid/outstanding in the expiring Policy Year:

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

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

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

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

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

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

(g) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for

each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.

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

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

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

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

(l) This clause does not alter Our right to decline a renewal or cancellation of the Policy for reasons as mentioned under Section F.I.6

D.II.2. Healthy Rewards

You can earn reward points equivalent to 1% of premium paid including taxes and levies for each Policy. In addition to this You can accumulate rewards by opting for an array of Our wellness programs listed below, that will help You to assess Your health status and aid in improving Your overall well-being. Each specific program can be opted only once by a particular Insured Person.

There will be no limitation to the number of programs one can enrol for in a single Policy Period. However, the maximum earning of Healthy Rewards on a Policy will be limited to 10% of premium paid in that Policy Period.

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

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

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

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

- A discount in premium from 1st Renewal of the Policy.
- As equivalent value while availing services through any of Our Network Providers as defined in the Policy.
- Equivalent value of Health Maintenance Benefit anytime during the Policy. (Applicable if HMB optional cover has been opted under ProHealth Select (A))

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

Policyholder/Insured can approach Us for redemption anytime during the policy period. For availing a discount on renewal premium, the same will be available only at the time such renewal is due.

Any earned reward points will lapse at the end of the grace period if the policy is not renewed with us.

The notifications related to wellness programs will be communicated via SMS, email and the program specific phone / web application. Details about reward points will be available on program app or shared through SMS or renewal notice sent to customers.

D.III. OPTIONAL COVERS

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

D.III.1. Deductible:

We will provide for a Deductible on specific Sum Insured Options. Where ever a Deductible is selected such amounts will be applied for each Policy Year on the aggregate of all Claims in that Policy Year other than for claims under fixed Benefit Covers and Health Check Ups. Deductible shall apply to all sections other than Add On Riders, Health Maintenance Benefit and Health Check Up benefits if opted.

Any Voluntary Co-pay shall not apply to Policy with Deductible option.

For the purpose of calculating the deductible and assessment of admissibility all claims must be submitted in accordance with Section G.I.14 of Claims Process.

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

D.III.2. Voluntary Co-Pay (Applicable only for ProHealth Select (A)) :

Irrespective of the Age and number of claims made by the Insured Person and subject to the Co-payment option chosen by You, it is agreed that We will only pay 90% or 80% of any amount that We assess (payable amount) for the payment or reimbursement in respect of any Claim under the Policy made by that Insured Person and the balance will be borne by the Insured Person.

Co-pays shall apply to all sections other than Add on Riders, Health Maintenance Benefit and Health Check Up benefits if opted.

Co-pay will be applied on the admissible claim amount.

D.III.3. Cumulative Bonus Booster

You may choose one of the 4 Cumulative Bonus Options under the Policy as follows

Option a) We will increase the opted Sum Insured by 10% at the end of the Policy Year, up to a maximum of 100%, if the policy is Renewed with Us provided that there are no claims paid or outstanding in the expiring Policy Year.

In case of opting for Cumulative Bonus Booster D.III.3. (a), the Cumulative Bonus under section D.II (1) shall not be available, however all terms and conditions of the said section shall apply.

Option b) We will increase the Sum Insured by 25% at the end of the policy year, up to a maximum of 100%, if the policy is Renewed with Us provided that there are no claims paid or outstanding in the expiring Policy Year.

In case of opting for Cumulative Bonus Booster D.III.3. (b), the Cumulative Bonus under section D.II (1) shall not be available, however all terms and conditions of the said section shall apply.

Option c) We will increase in the opted Sum Insured by 50% for each claim free Policy Year, up to a maximum of 100%, when there are no claims paid or outstanding in the expiring Policy Year. In case of a claim being paid or remaining outstanding at the end of a Policy Year or at the time of Renewal of such Policy, the earned cumulative bonus will reduce by 50% in the subsequent year. However, this does not impact the opted Sum Insured.

In case of opting for Cumulative Bonus Booster D.III.3. (C), the Cumulative Bonus under section D.II. (1) shall not be available, however all terms and conditions except D.II (1). d & e. of the said section shall apply.

Option d) We will increase in the opted Sum Insured by 10% at the end of each Policy Year irrespective of a claim under the expiring Policy Year, up to a maximum of 200%.

In case of opting for Cumulative Bonus Booster D.III.3. (d), the Cumulative Bonus under section D.II. (1) shall not be available, however all terms and conditions except D.II (1). a.c. of the said section shall apply.

D.III.4. Removal of Room Rent Limit

We will provide for an option to remove the Room Rent limit applicable on the Inpatient Hospitalization and allow for coverage up to a Single Private Room. All terms and conditions of Inpatient Hospitalization under Section D.I.1 shall apply.

D.III.5. Re-Assurance

Under Re-Assurance, We will provide an automatic extension of Policy Renewal for a period of 2 (two) Policy Years from the date of expiry of the current policy, if during the Policy Period an Insured Person is diagnosed with any of the Critical Illnesses named below or suffers from Permanent Total Disability described below due to an Accident, provided that the Insured Person is not added in to the Policy mid-term and has attained 18 years of age at the inception of the Policy Year in which the event occurred.

This automatic extension will be available only once in the lifetime of an Insured Person, in respect of either a Critical Illness or a Permanent Total Disability Event which qualifies for coverage as per the criteria specified under this Policy, irrespective of the sequence of its occurrence.

Reassurance can be availed by each Insured Person separately in case of an individual policy and once during the lifetime of a Policy in case of floater policies covering all Insured Persons under the Floater. Where this extension is triggered for a child attaining age 24 years during subsequent renewals, both the parent and split policy of the child will be eligible for this automatic extension.

a) Critical Illnesses

If an Insured Person is diagnosed to be suffering from a Critical Illness (as listed below) while the Policy is in force as a first incidence the Policy will automatically extend for a period of 2 Policy Years.

For the purpose of this Policy, **Critical Illness** shall mean any Illness, medical event or Surgical Procedure as specifically defined below whose signs or symptoms first commence at least 90 days after the Inception of Policy Period. If such Critical Illness is acquired as a result of a pre-existing condition, then the standard waiting periods for pre-existing diseases shall apply.

1. Cancer of specified severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure Requiring Regular Dialysis
7. Stroke Resulting in Permanent Symptoms
8. Major Organ / Bone Marrow Transplant
9. Permanent Paralysis of Limbs
10. Motor Neuron Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms

b) Permanent Total Disability

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, the Policy will automatically extend for a period of 2 Policy Years provided that the Policy is in force at the time of such event.

Coverage for Permanent Total Disability due to Accident will start from day one.

1. Total and irrecoverable loss of sight of both eyes
2. Loss by physical separation or total and permanent loss of use of both hands or both feet
3. Loss by physical separation or total and permanent loss of use of one hand and one foot
4. Total and irrecoverable loss of sight of one eye and loss of a limb
5. Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
6. Total and irrecoverable loss of hearing of both ears and loss of speech
7. Total and irrecoverable loss of speech and loss of one limb/loss of sight of one eye
8. Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever

Automatic Renewal shall apply only to the base cover & any Optional Covers excluding Add On Riders, on the same terms as per the expiring policy and any change in terms or coverage or addition of Insured Persons at the time such Renewal is due shall be subject to underwriting as per the standard renewal process and payment of any additional premium if any change is accepted by Us.

All Claims under this benefit can be made as per process defined under Section G.I.18

D.III.6. Health Check Up (Applicable only for ProHealth Select (A)):

(a) We will provide for Health check-up for each and every Insured Persons above the age of 18 years. Health Check Ups will be and arranged by Us and conducted at Our Network Providers. Any claim under this benefit shall not impact Cumulative Bonus. Health Check-Ups will be available once each year.

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

ProHealth Select	Sum Insured (in Rs.)	Age	List of tests
(A)	0.5, 1, 2, 3 Lacs	From 18 Years onwards	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT
(A)	4 ,5, 7, 10 Lacs	18 to 40 Years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT
		More than 40 Years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT For females only – TSH
(A)	15, 20, 25 Lacs	18 to 40 years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
		More than 40 years (For males only)	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR Lipid Profile, SGOT, GGT, TMT
		More than 40 years (For females only)	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT

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

(c) Coverage under this value added cover will not be available on reimbursement basis. All Claims under this benefit can be made as per the process defined under Section G.I.12

(d) You understand and agree that the list of medical tests covered above are indicative and We may add, modify or amend this list on approval from the Head of Underwriting.

D.III.7. Worldwide Emergency Cover (Applicable only for ProHealth Select (A)):

We will cover Medical Expenses of the Insured Person incurred outside India up to the Sum Insured provided that:

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

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

(c) Any payment under this Benefit will only be made in India, in Indian rupees on a re-imbursement basis and subject to Sum Insured. Cashless Facility may be arranged on a case to case basis. Insured person can contact Us at the numbers provided on the Health Card for any claim assistance.

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

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

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

(g) Exclusion E.II.6 does not apply to this benefit.

All Claims under this benefit can be made as per the process defined under Section G.I 5 & 13 .

D.III.8. Disease Specific Sub limit (Applicable only for ProHealth Select (A))

You may choose to opt for Disease Specific Sub Limit on an optional basis under the ProHealth Select (A).

The balance amount, if any, subject to the applicability of sub-limits on expenses on treatment of Named ailments / Procedures, our liability to make payment shall be limited to such extent as applicable.

Maximum payable per surgery or medical management cost per policy period

	Sub-Limit (Amount in ₹)			
	Ailments/ Surgeries / Medical Procedures	**Option 1**	**Option 2**	**Option 3**
1	Cataract (Per eye)	7,500	15,000	22,500
2	Surgeries for Non-malignant Tumors/Cysts/Nodule/Polyp/ Benign Prostate Hypertrophy	15,000	30,000	45,000
3	Stone in Urinary/Biliary System	20,000	40,000	60,000
4	Hernia (per side)	12,500	25,000	37,500
5	Appendicitis	10,000	20,000	30,000
6	Hysterectomy	15,000	30,000	45,000
7	Any Joint Replacement	40,000	60,000	80,000
8	Piles/Fissures/Fistula	10,000	20,000	30,000
9	Medical Management or Surgeries related to Ischemic Heart Disease / Cardiac	40,000	60,000	80,000
10	Treatment for Injuries/ Breakage of Bones	27,500	55,000	80,000
11	Cerebrovascular Medical Management/Surgery	25,000	50,000	75,000
12	Cancer/Oncology (Medical & Surgical)	40,000	60,000	80,000
13	Abscess/Ligament Tear	20,000	40,000	60,000
14	Treatment towards Kidney damage or renal failure	40,000	60,000	80,000

D.III.9 Health Maintenance Benefit (Applicable only for ProHealth Select (A))

We will cover, only by way of reimbursement costs towards Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred on an Out Patient basis upto the amount specified under this benefit.

We will cover costs incurred towards:

- Diagnostic tests, preventive tests, drugs, prosthetics, medical aids, prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule.
- Towards Dental Treatments and Alternative Forms of Medicines wherever prescribed by a Medical Practitioner.

Any unutilised HMB limit shall lapse at the end of the Policy Year and fresh limits will be under the new Policy Year.

D.III.10 . Rider/Add On Benefit:

Along with this Policy, You can also avail the ManipalCigna Critical Illness and ManipalCigna Health 360 add on Cover. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All terms and conditions of the applicable rider including medical check-up requirements will apply.

E. Exclusions

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

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 36 months of continuous coverage after the date of inception of the first policy with us.

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

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

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

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

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

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

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

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

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

f. List of specific diseases/procedures provided:

I) Cataract,

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

iii) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, any internal congenital anomalies, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertibral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal,

iv) Varicose Veins and Varicose Ulcers,

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

vi) Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

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

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.

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.

b. This also includes:

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

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

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

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

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

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

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

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

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

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

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

E.II. Specific Exclusions

E.II.1. 90-day waiting period for Critical Illness under Re-Assurance & Add On Cover (if opted)

Any critical illness contracted and/or signs and symptoms first commenced during the first 90 days from the Inception Date of the policy will not be covered under the critical illness benefit wherever opted.

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

E.II.3. Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.

E.II.4. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

E.II.5. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.

E.II.6. Treatment received outside India other than for coverage under Worldwide Emergency Cover.

E.II.7. 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.8. All expenses directly or indirectly, 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.9. For complete list of non-medical items, please refer to the Annexure IV, List I of "Non-Payable Items" and also on Our website

E.II.10. Any form of Alternative Treatment, except Inpatient for AYUSH.

E.II.11. 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.

E.II.12. 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.13. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

E.II.14. 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.15. Any deductible amount or percentage of admissible claim under co-pay or above Sub-Limit if applicable and as specified in the Schedule to this Policy.

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 30 days from the date of receipt of last necessary document.

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

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

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

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

F.I.4. Multiple Policies

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

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

iii. If the amount to be claimed exceeds the Sum Insured under a single policy the Insured Person shall have the right to choose insurers from whom he/she wants to claim the balance amount.

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

F.I.5. 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. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or;

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

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

F.I.6. Cancellation

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

Cancellation grid: (Applicable for Single and Yearly premium payment

mode) Refund Grid as % of Premium			
Policy Cancelation Within (Days)	**Policy 1 Year**	**Policy 2 Year**	**Policy 3 Year**
0 - 30 Days	85.00%	87.50%	89.00%
31 - 90 Days	75.00%	80.00%	82.50%
91 - 181 Days	50.00%	70.00%	75.00%
182 - 272 Days	30.00%	60.00%	70 .00%
273 - 365 Days	0.00%	50.00%	60.00%
366 - 456 Days	NIL	35.00%	55.00%
457 - 547 Days		25.00%	45.00%
548 - 638 Days		15.00%	40.00%
639 - 730 Days		0.00%	30.00%
731 - 821 Days		NIL	25.00%
822 - 912 Days			15.00%
913 - 1003 Days			5.00%
1004 and more Days			0.00%

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

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

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

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

F.I.7. Grace Period

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

F.I.8. 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.
- During such Grace period, coverage will not be available from the due date of instalment premium payment till the date of receipt of premium by Company.
- 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.
- The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

F.I.9 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30/15, 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.10. 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.11. Portability

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

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

F.I.12. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently

covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

F.I.13. Complete Discharge

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

F.I.14. Redressal of Grievance

In case of a grievance, you can contact us through our website: https://www.manipalcigna.com/grievance-redressal

You can reach us at our Toll Free: 1800-102-4462

For Senior Citizen you can write to us at mail to:

Seniorcitizensupport@manipalcigna.com

Post/Courier/Walk-in: Any of Our Branch office or corporate office at the addresses available on https://www.manipalcigna.com/locate-us

If in case you are not satisfied with the response then write to us at: headcustomercare@manipalcigna.com

If the channels above have still not met your expectations, you may approach the insurance ombudsman, the office Name and address details applicable for your state can be obtained from the following link https://www.cioins.co.in/Ombudsman on the IRDAI Website

Note: If you are not satisfied with the decision provided by any of the above authorities, you can approach the company within 8 weeks from the date of receipt of response by the insured/policyholder.

You may also approach the Insurance ombudsman if your complaint is open for more than 30 days at any of the above levels

In case of no response within 8 weeks your grievance will stand close.

F.I.15. 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.16. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

F.I.17. Nomination

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

F.I.18. Moratorium Period

After completion of 60 continuous months of coverage (including portability and migration) under this policy no look back would be applied. This period of 60 months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

F.II. Specific terms and clauses

F.II.1. Material Change

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

F.II.2. Records to be maintained

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

F.II.3. Alterations in the Policy

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

F.II.4. Change of Policyholder

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

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

F.II.5. No Constructive Notice

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

F.II.6. 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.

F.II.7. Geography

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

F.II.8. 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.9. Renewal Terms

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

b. In case the coverage under the Re-Assurance is triggered, Renewals will be effected accordingly for the immediate two Policy Years and customer will not require to pay any premium for such renewals, provided the terms and conditions of the contract are not altered. Post completion of the said period, all renewals shall be subject to standard renewal terms under this section.

c. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-existing Condition.

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

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

f. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

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

h. Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods shall apply afresh for this enhanced limit from the effective date of such enhancement.

I. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 36 consecutive months of the policy.

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

k. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the Policy.

l. In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Cumulative Bonus earned on the Policy will stay with the floater cover.

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

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

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

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

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

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

F.II.10. Premium calculation

The Premium charged on the Policy will depend on the Sum Insured, Policy Tenure, Age, Zone, Policy Type, Optional Covers, Premium Payment mode and Add On Benefits opted. Additionally, the health status of the individual will also be considered.

Premium can be paid on Single, Yearly, Half yearly, Quarterly and Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy. In case of premium payment modes other than Single and Yearly, a loading will be applied on the premium.

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

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

If we receive any amount in excess of the required premium, we will refund the excess without paying any interest on the excess amount. If we receive any amount lesser than the required premium, the same shall not be adjusted towards the premium and no interest shall be paid on the amount. You will not be entitled to any benefits or claims under the policy unless you pay the full premiums in time.

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

a. Payment of premium and loading, if any.

b. Minimum premium requirement for the requested premium payment mode, if any.

c. Availability of the requested premium payment mode on the day of implementation of request.

d. Premium rates/ tables applicable for the changed premium payment mode will be the same as the premium rates/ tables applicable on the date of commencement of policy.

F.II.11. Loadings, Special Conditions & Discounts

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 for insurance and declarations made in the Proposal Form. These loadings will be applied from inception date of the first Policy including subsequent Renewal (s) with Us. There will be no loadings based on individual claims experience. Maximum Risk Loading per individual shall not exceed 100% of Premium excluding Statutory Levies and Taxes.

We may apply a specific sub-limit on a medical condition/ailment depending on the past history and declarations on pre-existing diseases as part of the special conditions on the Policy.

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

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

Details of applicable loadings by ailments/ medical test results are listed as below.

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

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

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

Additional Sub-limit applied on Special Conditions: The Policy will pay only 75% of the payable claim amount arising out of the specified illness/medical condition as listed above and its complications as declared by the Insured Person or diagnosed at the time of pre acceptance medical tests. Admissible claim amount will be calculated after all the co-pays applicable under the Policy have been accounted. This condition will be applicable for a maximum of 36 months from the date of inception of first policy.

F.II.12. Discounts under the Policy

The Policy will allow the following Discounts.

1. Portfolio Discount (Only for ProHealth Select (A)):

a) Portfolio Gender Mix Discount: If the proportion of female members In an Affinity portfolio is 20% or more, then discounts will be applicable as per the following table:

Portfolio Gender Mix Discount	
Female Proportion	**Discount**
Proportion < 20%	0.0%
20% <= Proportion < 40%	2.5%
40% <= Proportion < 60%	5.0%
60% <= Proportion < 80%	7.5%
80% <= Proportion < 100%	10.0%

b) **Portfolio Region Mix Discount:** If the proportion of members in an Affinity portfolio outside of Zone 1 is 20% or more, then discounts will be applicable as per the following table:

Portfolio Region Mix Discount		
Population Proportion	**Zone 2**	**Zone 3**
Proportion < 20%	0.0%	0.0%
20% <= Proportion < 40%	2.0%	4.0%
40% <= Proportion < 60%	4.0%	8.0%
60% <= Proportion < 80%	6.0%	12.0%
80% <= Proportion < 100%	8.0%	16.0%

Notes:

i. Zones are defined as under:

Zone 1: Mumbai, Thane, Navi Mumbai, Delhi and NCR

Zone 2: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Gujarat

Zone 3: Rest of India excluding locations mentioned under Zone 1 and Zone 2

ii. For a portfolio with exposure to only Zone 1 & Zone 2, discounts as per the Zone 2 column above will be available as per the proportion of the portfolio in Zone 2.

iii. For a portfolio with exposure to only Zone 1 & Zone 3, discounts as per the Zone 3 column above will be available as per the proportion of the portfolio in Zone 3.

iv. For a portfolio with exposure to Zone 1, Zone 2 & Zone 3, then the average of the discounts as per the Zone 2 & Zone 3 columns above will be available as per the total proportion of the portfolio in Zones 2 & 3.

Portfolio discounts will be calculated at the portfolio level based on the base premium rates for ProHealth Select (A)

Applicable portfolio discount will apply on all policies offered to members of the Affinity portfolio.

The maximum Portfolio discount on offer for a single Affinity partner will be limited at 26%.

The premium for any of the optional benefits, such as Cumulative Bonus Booster, Room Rent Cap Waiver and Reassurance Health Check-up, Worldwide Emergency Cover, Health Maintenance Benefit, will then be charged relative to the discounted premium rate for the base plan.

Any loading for Medical Underwriting at an individual policyholder level will be applicable on the discounted premium rate offered for the portfolio.

2. **Family Discount:** Discount offered is 10% for policies covering more than 2 individuals with individual Sum Insured.

3. **Long Term Discount:** Discount offered is 7.5% for policies with term 2 years and 10% for policies with term 3 years, only upon payment of lump sum premium. The discount is available only with Single Premium Payment Mode.

Family and Long Term Discounts will be available for both ProHealth Select (A) and (B) variants. For the ProHealth Select (A), these discounts will be over and above the 26% cap for Portfolio discounts.

4. **Zone Discount (Only for ProHealth Select (B)):** Discount offered is 8% for customer from Zone 2 and 16% for customer from Zone 3.

Zone Classification

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

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

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II Identification of Zone will be based on the City of the proposed Insured Persons.

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

(b) Persons paying Zone II premium

i) Can avail treatment in Zone II and Zone III without any co-pay.

ii) Availing treatment in Zone I will have to bear 10% of each and every claim.

(c) Person paying Zone III premium

i) Can avail treatment in Zone III, without any co-pay

ii) Availing treatment in Zone II will have to bear 10% of each and every claim.

iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

***Option to select a Zone higher or lower than that of the actual Zone is available on payment of relevant premium at the time of buying the policy or at the time of renewal. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalization due to an Accident.

F.II.13. Dispute Resolution

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

F.II.14. Communications & Notices

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

a. The policyholder's, at the address as specified in Schedule

b. To Us, at the address specified in the Schedule.

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

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

F.II.15. Electronic Transactions

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

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

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

G. Other terms and conditions

G.I. Claim process & management

G.I.1. Condition Preceding

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

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

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

Cashless and Reimbursement Claim processing and access to network hospitals is through Our service partner, details of the same will be available on the Health Card issued by Us as well as on Our website. For the latest list of network hospitals, You can log on to Our website.

A TPA will be used for Network Access and facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

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

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

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

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

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

(c) If so requested by Us, You or the Insured Person must submit himself/ herself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and

necessary. The cost of such examination will be borne by Us.

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

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

G.I.3. Claim Intimation

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

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

- Planned Hospitalization, You/the Insured Person will intimate such admission at least 3 days prior to the planned date of admission.
- Emergency Hospitalization, You /the Insured Person will intimate such admission within 48 hours of such admission.

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

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

G.I.4. Cashless Facility

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

(a) For Planned Hospitalization:

i. The Insured Person should at least 3 days prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.

ii. The Network Provider will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDAI.

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

iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.

v. Wherever the information provided in the request is sufficient to ascertain the authorisation We shall issue the authorisation Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 4 hours from the receipt of last complete documents.

vi. The Authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any, sub-limits, co-pays or deductibles and non-payable items if applicable.

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

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

i. The Network Provider shall request Us for an enhancement of authorisation limit as described under Section 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 24 (twenty four) hours of receiving the request for enhancement from You.

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

At the time of discharge:

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

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

(b) In case of Emergency Hospitalization

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

ii. The Network Provider shall forward the request for authorization within 48 hours of admission to the Hospital as per the process under Section G.I.4 (a).

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

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

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

Note: Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy and shall not be available to the Insured Person for coverage under Worldwide Emergency Cover (Section D.I.8) For all Cashless authorisations, You will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub-limits (if applicable), Co-payment and / or Deductibles (if applicable), directly with the Hospital.

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

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

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

There can be instances where We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for

reimbursement to Us which will be considered subject to the Policy Terms &Conditions.

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

G.I.5. Claim Reimbursement Process

(a) Collection of Claim Documents

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

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

Claim form duly signed
Copy of photo ID of patient
Hospital Discharge summary
Operation Theatre notes
Hospital Main Bill
Hospital Break up bill
Investigation reports
Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Doctors reference slip for investigation
Pharmacy Bills
MLC/ FIR report, Post Mortem Report if applicable and conducted

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

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

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

G.I.6. Scrutiny of Claim Documents

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

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

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

d. We may at our sole discretion decide to deduct the amount of claim for which deficiency is intimated to the insured person and settle the claim if we observe that such a claim is otherwise valid under the policy.

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

G.I.7. Claim Assessment

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

a) <u>For Policy without Deductible Option</u>

i) Where a room accommodation is opted for higher than the eligible room category/room rent under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

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

b) <u>For Policy with Deductible Option</u>

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Arrived payable claim amount will be assessed against the deductible after applying the Section G.I.7 b (i).

iii) Any Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7.b (ii)

c) <u>For Policy without 'Disease Specific Sub-limit' Option</u>

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Any 'Voluntary Co-payment' or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7.c (i)

d) <u>For Policy with 'Disease Specific Sub-limit' Option</u>

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Arrived payable claim amount will be assessed against the Disease Specific Sub-limit.

iii) Any 'Voluntary Co-payment' or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7.d (i) & (ii)

e) <u>For Policy with Deductible and 'Disease Specific Sub-limit' option</u>

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Arrived payable claim amount will be assessed against the deductible after applying G.I.7.e (i).

iii) Arrived payable claim amount will be assessed against the Sub-limit after applying G.I.7.e (i) & (ii).

iv) Any 'Zonal Co-payment' shall be applicable on the amount payable after applying the Section G.I.7. e (i), (ii) & (iii)

The Claim amount assessed under Section G.I.7 a, b, c, d, & e will be deducted from the available covers in the following progressive order -

i) Sum Insured

ii) Cumulative Bonus (or Cumulative Bonus Booster if opted)

iii) Restored Sum Insured

G.I.8. Claims Investigation

We may investigate claims at Our own discretion to determine the validity of claim. Such investigation shall be concluded within 15 days from the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. Verification carried out, if any, will be done by individuals or entities authorised by Us to carry out such verification / investigation (s) and the costs for such verification / investigation shall be borne by the Us.

G.I.9. Pre and Post-hospitalization claims

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

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

and conditions, derived on the basis of documents received.

G.I.10. Representation against Rejection:

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

G.I.11. Payment Terms

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

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

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

For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.

For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death, We will pay the nominee (as named in the Policy Schedule) and in case of no nominee to the Legal Heir who holds a succession certificate or Indemnity Bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of its liability under the Policy.

Claim process Applicable to the following Sections:

G.I.12. Health Check up

(a) You or The Insured Person shall seek appointment by calling Our call centre.

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

G.I.13. Worldwide Emergency Cover

a) In an unlikely event of You or the Insured Person requires Emergency medical treatment outside India, You or Insured Person, must notify Us either at Our call centre or in writing within 48 hours of such admission.

b) You shall file a claim for reimbursement in accordance with Section G.I.5 & Section G.I.13 of the Policy. Under special circumstances due to an emergency we, may consider offering a cashless option on a case to case basis.

G.I.14. Deductible

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

b) Wherever such Hospitalization claims as stated under G.I.14. a) above is being covered under another Policy held by You, We will assess the claim on available photocopies duly attested by Your Insurer / TPA as the case may be.

G.I.15. Re-Assurance

a) In the event of an Insured Person suffering from any of the named Critical Illnesses, You or the Insured Person, may intimate Us with the following documents.

In respect of Permanent Total Disability

- Claim Form Duly Signed
- Original treating Medical Practitioner's certificate describing the disablement;
- Original Discharge summary from the Hospital;
- Photograph of the Insured Person reflecting the disablement;
- Prescriptions and consultation papers of the treatment;
- Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.

In respect of Critical Illness

- Claim form duly filled and signed Part A and B wherever applicable;
- Medical Certificate confirming the diagnosis of Critical Illness;
- Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy.
- Discharge Card/Death Summary from the Hospital, if applicable;
- Investigation test reports confirming the diagnosis as specified under the definition of the respective Critical Illnesses;
- First consultation letter and subsequent prescriptions;
- Indoor case papers if applicable;
- KYC documents;
- Specific documents listed under the respective Critical Illness
- In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will also be required wherever conducted. We may call for any additional necessary documents / information as required based on the circumstances of the claim.
- In the unfortunate event of the death of the insured person post the survival period, any person claiming on in respect of the Insured Person under the Policy must inform Us in writing immediately.

G.I.16. Disease Specific Sub-Limit

Any claim towards Hospitalization during the Policy Period must be submitted to Us for scrutiny in accordance with the claim process laid down under G.I.4 and G.I.5 above, towards cashless or reimbursement respectively in order to assess and determine the applicability of the Sub-limit on such claim. Once the claim has been assessed, if any amount becomes payable within the Sub limit, We will assess and pay such claim in accordance with Section G.I.6 and G.I.7 above.

G.I.17. Health Maintenance Benefit

a) Submission of claim

Insured person can send the Health Maintenance Benefit claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to Our branch office or head office. The Health Maintenance Benefit under opted variant can be claimed only once for one of more Out Patient treatments during the Policy Year up to the extent of Health Maintenance Benefit limit plus any earned Healthy Rewards converted to Health Maintenance Benefit

b) Assessment of Claim Documents

We shall assess the claim documents and assess the admissibility of claim as per the terms & conditions of the Policy.

c) Settlement & Repudiation of a claim

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

G.I.18. Critical Illness Add On Cover (wherever opted)

In the event of a claim arising out of any of the listed Critical Illnesses, the Insured Person shall submit the claim documents to Us within ninety (90) days of date of first diagnosis of the Illness/ date of surgical procedure or date of occurrence of the medical event, as the case may be.

Insured Person shall submit the following documents in original for assessment and upon request we will return the Original documents.

- Claim form duly filled and signed Part A and B wherever applicable;

ManipalCigna Health Insurance

G.II. Annexure - I:
Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079-25501201/02/05/06 Email:- bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080-26652048/26652049 Email:- bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003 Tel.: 0755-2769201/202 Fax: 0755-2769203 Email:- bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar - 751 009. Tel.: 0674-2596461/2596455 Fax: 0674-2596429 Email:- bimalokpal.bhubaneswar@cioins.co.in	State of Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172-2706196/6468 Fax: 0172-2708274 Email:- bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044-24333668/24335284 Fax: 044-24333664 Email:- bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011-23232481/23213504 Email:- bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361-2132204/2132205 Email:- bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040-65504123/23312122 Fax: 040-23376599 Email:- bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.

- Medical Certificate confirming the diagnosis of Critical Illness;
- Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy.
- Discharge Card/Death Summary from the Hospital, if applicable;
- Investigation test reports confirming the diagnosis as specified under the definition of the respective Critical Illnesses;
- First consultation letter and subsequent prescriptions;
- Indoor case papers if applicable;
- KYC documents;
- Specific documents listed under the respective Critical Illness
- In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will also be required wherever conducted. We may call for any additional necessary documents / information as required based on the circumstances of the claim.

In the unfortunate event of the death of the insured person post the survival period, any person claiming in respect of the Insured Person under the Policy must inform Us in writing immediately.

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

G.III. Annexure - II:

List of Day Care Treatments/Surgeries/Procedures covered under Section D.I.4 including but not limited to the following:

Microsurgical Operations on the middle ear

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

Other operations on the middle & internal ear

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

Operations on the nose & the nasal sinuses

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

Operations on the eyes

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

Operations on the skin & subcutaneous tissues

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

Operations on the tongue

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

Operations on the salivary glands & salivary ducts

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

Other operations on the mouth & face

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

Operations on tonsils and adenoids

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

Operations on the breast

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

Operations on the digestive tract, Kidney and bladder

90. Incision and excision of tissue in the perianal region
91. Surgical treatment of anal fistulas
92. Surgical treatment of haemorrhoids
93. Division of the anal sphincter (sphincterotomy)
94. Other operations on the anus
95. Ultrasound guided aspirations
96. Sclerotherapy etc.
97. Laprotomy for grading Lymphoma with Splenectomy/ Liver/ Lymph Node Biopsy
98. Therapeutic laproscopy with Laser
99. Cholecystectomy and choledocho – jejunostomy/ Duodenostomy/ Gastrostomy/ Exploration Common Bile Duct
100. Esophagoscopy, gastroscopy, dudenoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions
101. Lithotripsy/ Nephrolithotomy for renal calculus
102. Excision of renal cyst
103. Drainage of Pyonephrosis/ Perinephric Abscess
104. Appendicectomy with/ without Drainage

Operations on the female sexual organs

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

Operations on the prostate & seminal vesicles

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

Operations on the scrotum & tunica vaginalis testis

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

Operations on the testes

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

Operations on the spermatic cord, epididymis and ductus deferens

143. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
144. Excision in the area of the epididymis
145. Epididymectomy

Operations on the penis

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

Operations on the urinary system

150. Cystoscopical removal of stones
151. Catheterisation of bladder

Other Operations

152. Lithotripsy
153. Coronary angiography

G.IV. Annexure - III:

		ProHealth Select (A)	ProHealth Select (B)
	Sum Insured	₹0.50, 1, 2, 3, 4, 5, 7, 10, 15,20,25 Lacs	₹ 2, 3, 4, 5, 7,10,15, 20, 25, Lacs
Basic Cover	**Inpatient Hospitalization**	Covered up to 2% of Sum Insured for a Hospital Room, up to a max of ₹3,000 OR Up to 4% of Sum Insured for ICU up to a max of ₹7,000	
	Pre - Hospitalization	60 days	
	Post - Hospitalization	90 days	
	Day Care Treatment	171 procedures, Covered up to full sum insured	
	Domiciliary Treatment	Covered up to the limit of Sum Insured opted	
	Ambulance Cover	Covered upto ₹ 2000 per Hospitalization event	
	Donor Expenses	Covered upto full Sum Insured	
	Restoration of Sum Insured	Available once in a policy year for unrelated illnesses in addition to the Sum Insured opted. Available for all Sum Insured's except ₹ 0.5L and ₹ 1L	
	AYUSH Cover	Coverage for Ayurvedic, Yoga & Naturopathy, Unani, Siddha and Homeopathy up to Sum Insured limits.	
Value Added Covers	**Cumulative Bonus**	5% each year maximum upto 100%.This will not be reduced in case of claim under the Policy.	
	Healthy Rewards	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used to get a discount in premium from the next renewal OR they can be redeemed for availing services through any of Our network providers as defined in the policy OR Equivalent value of Health Maintenance Benefit anytime during the Policy. (Applicable if HMB optional cover has been opted under ProHealth Select (A))	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used to get a discount in premium from the next renewal OR they can be redeemed for availing services through any of Our network providers as defined in the policy
Optional Covers	**Deductible***	Deductible - ₹1/2/3/4/5 Lacs in all combinations provided the Deductible is not higher than the Sum Insured opted.	Deductible - ₹1/2/3/4/5 Lacs in all combinations provided the Deductible is not higher than the Sum Insured opted.
	Voluntary Co-pay*	10% or 20% voluntary co-payment for each and every claim as opted on the Policy	Not Available
	Cumulative Bonus Booster (any one of the 4 choices)	a) 10% increase in Sum Insured, maximum up to 100%. This will not reduce in case of a claim under the Policy. b) 25% increase in Sum Insured, maximum up to 100%. This will not reduce in case of a claim under the Policy. c) 50% Increase in Sum Insured, maximum up to 100%. This will reduce by 50% in case of claim under the Policy, but in no case shall the Sum Insured be reduced. d) 10% increase in Sum Insured, maximum up to 200% irrespective of a claim under the Policy.	
	Removal of room rent Limit	Covered up to Single Private Room	
	Health Check-up	Every year for all Insured Persons above 18 years based on the applicable Grid.	Not Available
	Re-Assurance	Automatic Extension of Policy for 2 years on diagnosis of a Critical Illness or Permanent Total Disability due to Accident	
	Disease Specific Sub Limits	As per limits specified	Not Available
	Health Maintenance Benefit	Covered up to ₹500 or 1000 as opted	Not Available
	Worldwide Emergency Cover	Covered up to full Sum Insured once in a policy year	Not Available
	Add On Cover	ManipalCigna Critical Illness Add On Cover	
		ManipalCigna Health 360 OPD: ManipalCigna Health 360-Shield: Coverage for listed Non-medical items up to base policy Sum Insured and Durable Medical Equipment up to maximum of Rs.1 Lac	
		ManipalCigna Health 360 OPD: ManipalCigna Health 360- OPD Package 1: Coverage for doctor consultations on cashless basis within the OPD Sum Insured Package 2: Coverage for doctor consultations and prescribed diagnostics on cashless basis within the OPD Sum Insured Package 3: Coverage for doctor consultations, prescribed diagnostics and pharmacy on cashless basis within the OPD Sum Insured. Pharmacy limit is 20% of the OPD Sum Insured	

*Voluntary Co-pay and Deductible cannot be taken under a single Policy.

154. Biopsy of Temporal Artery for Various lesions
155. External Arterio-venus shunt
156. Haemodialysis
157. Radiotherapy for Cancer
158. Cancer Chemotherapy
159. Endoscopic polypectomy

Operation of bone and joints

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

Manipal Cigna Health Insurance

Annexure - IV:

S.NO.	ITEM
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