

MANIPALCIGNA PROHEALTH INSURANCE

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

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 it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken.
3. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with the following criterion:
 - i. having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.
4. **AYUSH Hospital** is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner (s) comprising any of the following:
 - i) Central or State Government AYUSH Hospital; or
 - ii) Teaching hospitals attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for 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.
5. **AYUSH Treatment** refers to the medical and/or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
6. **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.
7. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent

pre-authorization approved.

8. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.
9. **Condition Precedent** means a policy term or condition upon which the Insurer's Liability under the Policy is conditional upon.
10. **Congenital Anomaly** refers to a condition (s) which is present since birth, and which is abnormal with reference to form, structure or position.
 - a. **Internal Congenital Anomaly** - which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly
 - b. **External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body.
11. **Critical Illness** means the following:
 - a) **Cancer of Specified Severity**
A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
 - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
 - vi. Chronic lymphocytic leukaemia less than RAI stage 3
 - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
 - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
 - b) **Myocardial Infarction (First Heart Attack of Specific Severity)**
 - I The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:
 - i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
 - ii. new characteristic electrocardiogram changes
 - iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
 - II The following are excluded:
 - i. Other acute Coronary Syndromes
 - ii. Any type of angina pectoris.
 - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.
 - c) **Open Chest CABG**
 - I The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery (s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be

supported by a coronary angiography and the realisation of surgery has to be confirmed by a cardiologist.

II The following are excluded:

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

d) Open Heart Replacement or Repair of Heart Valves

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

e) Coma of Specified Severity

1. A state of unconsciousness with no reaction or response to external stimuli or internal needs.

This diagnosis must be supported by evidence of all of the following:

- i. no response to external stimuli continuously for at least 96 hours;
- ii. life support measures are necessary to sustain life; and
- iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

2. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

f) Kidney Failure Requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

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

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are excluded:

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

i) Permanent Paralysis of Limbs

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

j) Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent

functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

k) Multiple Sclerosis with Persisting Symptoms

- I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- II. Neurological damage due to SLE is excluded.

12. Cumulative Bonus

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

13. Day Care Centre - A day care centre means any institution established for day care treatment of illness and/or injuries or a medical set-up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

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

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

- i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
- ii) Which would have otherwise required a Hospitalization of more than 24 hours.

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

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

16. Dental Treatment Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

17. Disclosure to Information Norm means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

18. Domiciliary Hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

19. Emergency Care means management for a severe 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.

- 20. 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.
- 21. 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.
- 22. 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.
- 23. Illness** means a 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:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 2. it needs ongoing or long-term control or relief of symptoms
 3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 4. it continues indefinitely
 5. it recurs or is likely to recur
- 24. 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.
- 25. 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.
- 26. 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.
- 27. Maternity expenses** means:
- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
 - ii. Expenses towards lawful medical termination of pregnancy during the Policy Period
- 28. Medical Advice** means any consultation or advise from a Medical Practitioner including the issue of any prescription or follow-up prescription.
- 29. Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advise of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
- 30. 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.
- 31. Medical Practitioner** A Medical practitioner means a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by Government of India or a State Government and is and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
- 32. New Born Baby** means baby born during the Policy Period and is Aged up to 90 days
- 33. Network Provider** means hospitals or health care provider enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
- 34. Non- Network Provider** Any hospital, day care centre or other provider that is not part of the network.
- 35. Notification of Claim** Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- 36. 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.
- 37. OPD Treatment** - OPD treatment is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-Patient.
- 38. Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
- a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
 - b) for which medical advice or treatment was recommended by, or received from, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
- 39. Pre-hospitalization Medical Expenses**
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 40. Post-hospitalization Medical Expenses**
Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
- i. Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and
 - ii. The inpatient Hospitalization claim for such Hospitalization is

admissible by the insurance company.

41. **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.
42. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
43. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
44. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
45. **Room Rent** Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
46. **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
47. **Unproven / Experimental treatment means** the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

C.II. Specific Definitions

1. **Age or Aged** is the age last birthday, and which means completed years as at the Inception Date
2. **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.
3. **Annexure** means a document attached and marked as Annexure to this Policy
4. **Associated Medical Expenses** shall include 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.
5. **Inception Date** means the Inception date of this Policy as specified in the Schedule
6. **Cosmetic Surgery** means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
7. **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.
8. **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.
9. **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.
10. **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.
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. **Maternity Sum Insured** means the sum specified in the Schedule against the Benefit
14. **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.
15. **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.
16. **Policy Year** means a period of 12 consecutive months within the Policy Period commencing from the Policy Anniversary Date.
17. **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.
18. **Restored Sum Insured** means the amount restored in accordance with Section D.I.9 of this Policy
19. **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).
20. **Single Private Room** means a single Hospital room with any rating and of most economical category available at the time of hospitalization with/without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. This excludes a suite or higher category.
21. **Specific Waiting Period** means a period up to 24 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.
22. **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.

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

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

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

D. Benefits covered 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 provided that the admission date of the Hospitalization due to Illness or Injury is within the Policy Year. We will pay Medical Expenses as shown in the Schedule for:

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

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

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

Under Inpatient 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.

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

- a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- b. Balloon Sinuplasty
- c. Deep Brain stimulation
- d. Oral chemotherapy
- e. Immunotherapy - Monoclonal Antibody to be given as injection
- f. Intra vitreal injections
- g. Robotic surgeries
- h. Stereotactic radio surgeries
- i. Bronchical Thermoplasty
- j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- k. IONM - (Intra Operative Neuro Monitoring)
- l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

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

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 that occurs during the Policy Year 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 that occurs during the Policy Year immediately post discharge of the Insured Person from the Hospital up to limits specified in the Schedule, provided that a Claim has been admitted under In-patient Benefit under Section 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 Plan opted.

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 otherwise have been covered for Hospitalization under the policy but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

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

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

- a) We will pay for Pre-hospitalization, Post-hospitalization Medical Expenses up to 30 days each.
- b) We shall not be liable under this Policy for any Claim in connection with or in respect of the following:
 - i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
 - ii. Arthritis, gout and rheumatism,
 - iii. Chronic nephritis and nephritic syndrome,
 - iv. Diarrhoea and all type of dysenteries, including gastroenteritis,
 - v. Diabetes mellitus and Insipidus,

- vi. Epilepsy,
- vii. Hypertension,
- ix. Pyrexia of unknown origin.

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

D.I.6. Ambulance Cover

- a. We will provide for reimbursement of Reasonable and Customary expenses up to limits specified in the Schedule that are incurred towards transportation of an Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury covered under the Policy in case of an Emergency, necessitating the Insured Person's admission to the Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.
- b. Reasonable and Customary expenses shall include:
 - (i) Costs towards transferring the Insured Person from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital; or
 - (ii) When the Insured Person requires to be moved to a better Hospital facility due to lack of super speciality treatment in the existing Hospital.

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

D.I.7. Donor Expenses

- a. We will cover In-patient Hospitalization Medical Expenses towards the donor for harvesting the organ up to the limits of the Sum Insured, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that -
- b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical 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 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. Worldwide Emergency Cover

We will cover Medical Expenses incurred during the Policy Year, for Emergency Treatments of the Insured Person incurred outside India, up to limits specified in the Schedule, provided that:

- (a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India and is payable under Section 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-imbursment basis and subject to Sum Insured. Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance. In case where Cumulative Bonus accumulated is used for payment of claim under this benefit, the maximum liability under a single Policy year shall not exceed the Opted Sum Insured including Cumulative Bonus or Cumulative Bonus Booster as applicable.
- (d) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
- (e) You have given Us, intimation of such 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.10 does not apply to this benefit.

All Claims under this benefit can be made as per the process defined under Section G.I.4 & G.I.15.

D.I.9. Restoration of Sum Insured

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

- a. The Sum Insured inclusive of earned Cumulative Bonus (if any) or Cumulative Bonus Booster (if opted & earned) is insufficient as a result of previous claims in that Policy Year.
- b. The Restored Sum Insured shall not be available for claims towards an Illness/ disease/ Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person.
- c. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under Section II of the Policy and shall not apply to the first claim in the Policy Year. No Restoration of the Sum Insured will be provided for coverage under Section D.I. 8. Worldwide Emergency Cover, Section D.I.12, Maternity Expenses, New Born Baby Expenses Section D.I.13 and First Year Vaccinations Section D.I.14.
- d. The Restored Sum Insured will not be considered while calculating the Cumulative Bonus/ Cumulative Bonus Booster.
- e. Such restoration of Sum Insured will be available for any number of times, during a Policy Year to each insured in case of an individual Policy and can be utilised by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.
- f. If the Policy is issued on a floater basis, the Restored Sum Insured will also be available on a floater basis.
- g. If the Restored Sum Insured is not utilised in a Policy Year, it shall not be carried forward to subsequent Policy Year.

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

- i. The Sum Insured
- ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)
- h. During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:
 - i. The Sum Insured
 - ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)
 - iii. Restored Sum Insured

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

D.I.10. AYUSH Cover

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

The Insured Person has undergone treatment in an AYUSH Hospital/ AYUSH Day Care Centre.

- i. The following exclusions will be applicable in addition to the other Policy exclusions:
 - Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation.

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

D.I.11. Health Maintenance Benefit

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

- i. an Out Patient basis for Protect, Plus, Preferred and Premier Plans
- ii. an Out Patient and In-patient basis for Accumulate Plan.

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

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

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

All Waiting Periods and Permanent Exclusions including Co-pay's applicable on the Policy under Section E shall not apply to this section.

All Claims under this benefit can be made as per the process defined under Section G.I.12. Further, all claims under this benefit will be subject to the any one claim limits specified under Section G.I.14 of the Policy.

D.I.12. Maternity Expenses

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

You understand and agree that:

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

- (b) The Insured Person should have been continuously covered under this Policy for at least 48 months before availing this Benefit, except in case of opting for 'Reduction in maternity waiting period' where the limit will be relaxed to 24 months of waiting.
 - (c) The cover under this Benefit shall be restricted to two live children only.
 - (d) The payment towards any admitted claim under this Benefit for any complication arising out of or as a consequence of maternity or child birth will be restricted to limits specified in the Schedule however any restored amount will not be available for coverage under this section.
 - (e) Pre or post natal Maternity Expenses will be covered within the Maternity Sum Insured under this Benefit however; any Pre or Post - hospitalization Expenses paid under Section D.I.2 and D.I.3, above will not be covered under this Benefit.
 - (f) Maternity Sum Insured available under Maternity Expenses will be in addition to Sum Insured.
 - (g) Applicable Deductible or Co-pay under the applicable plan shall also apply to this benefit.
 - (h) We will not cover the following expenses under Maternity Benefit:
 - i) Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.
 - ii) Medical Expenses for ectopic pregnancy. However, these expenses will be covered under the In - patient Hospitalization under Section D.I.1.
- All Claims under this benefit can be made as per the process defined under Section G.I.4 & G.I.5.

D.I.13. New Born Baby Expenses

Subject to a claim being admitted under Maternity Expenses Cover under Section D.I.12, We will cover.

- (a) Medical Expenses towards treatment of the New Born Baby while the Insured Person is Hospitalised as an In-patient for delivery.
- (b) The Reasonable and Customary Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits specified in the Schedule under Maternity Expenses without payment of any additional premium.
- (c) Subject to the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby into the Policy by way of an endorsement or at the next Renewal, whichever is earlier.

Applicable Deductible or Co-pay under the applicable plan shall also apply to this benefit.

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

D.I.14. First Year Vaccinations

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

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

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

9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

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

D.II. Value added covers

D.II.1. Health Check Up

(a) If the Insured Person has completed 18 years of Age, the Insured Person may avail a comprehensive health check-up with Our Network Provider as per the eligibility details mentioned in the table below. All Insured members above the age of 18 years will be eligible for a Health Check Up. Health Check Ups will be and arranged by Us and conducted at Our Network Providers.

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

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

(b) Original Copies of all reports will be provided to You.

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

Full explanation of Tests is provided here: Vitals - Height, Weight, Blood Pressure, Pulse, BMI, Chest Circumference & Abdominal Girth
 FBS - Fasting Blood Sugar, GGT - Gamma - Glutamyl Transpeptidase,
 ECG - Electrocardiogram, CBC-ESR - Complete Blood Count -

Erythrocyte Sedimentation Rate, SGPT - Test Serum Glutamic Pyruvate Transaminase, SGOT - Serum Glutamic Oxaloacetic Transaminase, TSH - Thyroid Stimulating Hormone, TMT - Tread Mill Test, USG - Ultrasound Sonography, PSA - Prostate Specific Antigen, Pap smear - Papanicolaou test

(c) Coverage under this value added cover will not be available on reimbursement basis. All Claims under this benefit can be made as per the process defined under Section G.I.14

D.II.2. Expert opinion on Critical Illness

You may choose to secure a second opinion from Our Network of Medical Practitioners, if an Insured Person is diagnosed with the covered Critical Illness during the Policy Year. The expert opinion would be directly sent to the Insured Person.

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

- (a) We have received a request from You to exercise this option.
- (b) That the expert opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner
- (c) This benefit can be availed once by an Insured Person during a Policy Year and once during the lifetime of an Insured Person for the same Illness.
- (d) This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
- (e) The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.
- (f) We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.
- (g) The expert opinion under this Policy shall be limited to covered Critical Illnesses and not be valid for any medico legal purposes.
- (h) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
- (i) For the purpose of this benefit covered Critical Illnesses shall include -

a) Cancer of Specified Severity

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded -

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

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

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

- i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
 - ii. new characteristic electrocardiogram changes
 - iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II The following are excluded:
- 1. Other acute Coronary Syndromes
 - 2. Any type of angina pectoris.
 - 3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra - arterial cardiac procedure.

c) Open Chest CABG

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

- II The following are excluded:
- a. Angioplasty and/or any other intra-arterial procedures

d) Open Heart Replacement or Repair of Heart Valves

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

e) Coma of Specified Severity

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

f) Kidney Failure Requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

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

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

- 1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end - stage failure of the relevant organ, or
- 2. Human bone marrow using haematopoietic stem cells. The

undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

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

i) Permanent Paralysis of Limbs

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

j) Motor Neuron Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

- I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - 1. investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
 - 2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
- II. Neurological damage due to SLE is excluded.

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

D.II.3. Cumulative Bonus

- a) On Sum Insured
We will increase Your Sum Insured as specified under the Plan opted at the end of the Policy Year if the Policy is renewed with Us:
 - a) No Cumulative Bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.
 - b) The Cumulative Bonus will not be accumulated in excess of 200% of the Sum Insured under the current Policy with Us under any circumstances.
 - c) Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of that Policy Year if the policy is renewed with us within grace period and will be available for any claims made in the subsequent Policy Year.
 - d) Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last policy year amongst all the expiring policies being merged.
 - e) Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
 - f) Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the revised Sum Insured on pro-rata basis.
 - g) Increase in Sum Insured: If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
 - h) Cumulative bonus shall not be available for claims made for maternity expenses, new born baby cover, first year vaccination.
 - i) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section F.I.6

b) On Health Maintenance Benefit for Accumulate Plan

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

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

D.II.4. Healthy Rewards

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

In an individual or floater policy:

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

Maximum rewards that can be earned in a single policy period will be limited to 20% of premium paid in the existing Policy.

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

Program Type	Points to be earned as a percentage of Policy Period Premium
Health Risk Assessment (HRA)/ Targeted Risk Assessment (TRA)	2.5%
Lifestyle Management Program (LMP)	3%
Chronic Condition Management Programs	3%
Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives	2% per program, Maximum 5 programs per policy year
Health Check Up	0.5%

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

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

- Against payable premium (including Taxes) from 1st Renewal of the Policy.
- Equivalent value of Health Maintenance Benefit anytime during the policy.
- As equivalent value while availing services through our Network Providers as defined in the Policy.

Details of Healthy Rewards earned on each Policy will be updated in

our records against the policy as and when earned. Accrual for reward points will be the same for 1, 2 & 3 year policies.

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

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

Refer Annexure - A below on the Illustration of Healthy Rewards.

Annexure - A - Illustration of Healthy Rewards

Illustration 1

Policy details:					
Policy Type - Individual					
Sum Insured - ₹10,00,000					
Policy Period - 1 Year (Example: 1 st Jan 2021 to 31 st Dec 2021)					
Insured Age - 30 Years					
Premium (inclusive of Taxes) for 1 year policy - ₹10,000					
(Premium indicated here is just for illustration purposes and may not be the actual premium.)					
Policy Year	Transaction Date	Particulars of Healthy Reward Points (HRP) Earned/ Utilized by Insured	HRP - Opening Balance/ Balance Brought Forward during the Policy Period	HRP (earned/ utilized) on Transaction Date during the Policy Period	HRP - Closing Balance
1	1 Jan, 2021	Reward points equivalent to 1% of premium paid including taxes	0	100	100
1	20 Jan, 2021	Completion of Health Risk Assessment (HRA) and Targeted Risk Assessment (TRA) during the Policy Period. Rewards equivalent to 2.5% of premium paid inclusive of taxes.	100	250	350
1	10 Sep, 2021	Completion of enrolled Lifestyle Management Program (LMP) during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	350	300	650
1	20 Sep, 2021	Completion of enrolled Chronic Condition Management Program during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	650	300	950

1	23 Sep, 2021	Participating in a ManipalCigna Sponsored Program – Total of 5 Programs during the Policy Period. Rewards equivalent to 10% (2% each per Program) of premium paid inclusive of taxes.	950	1000	1950
1	28 Sep, 2021	Health Check-Up. Rewards equivalent to 0.5% of premium paid inclusive of taxes.	1950	50	2000*

*Maximum reward that can be earned in a Policy Period is up to 20% of the premium paid including taxes. In this case, the maximum limit of 2000 (₹10000*20%) is achieved. Hence there shall not be any further earning of Healthy Rewards. However, earned reward points can be redeemed in the following ways
 - Against payable premium (including Taxes) from 1st Renewal of the Policy.
 - Equivalent value of Health Maintenance Benefit anytime during the Policy.
 - As equivalent value while availing services through our Network Providers as defined in the Policy.

1	15 Oct, 2021	500 points – Redeemed as equivalent value in Health Maintenance Benefit, during the Policy Period	2000	-500	1500
1	1 Nov, 2021	300 points – Redeemed as equivalent value for availing services through our Network Providers, during the Policy Period	1500	-300	1200
1	31 Dec 2021	1200 points – Redeemed against payable renewal premium (including taxes) at the time of Renewal	1200	-1200	0

Illustration 2

Policy details:

Policy Type - Individual
 Sum Insured - ₹10,00,000
 Policy Period – 2 Years (Example 1st Jan 2021 to 31st Dec 2022)
 Insured Age – 28 Years
 Premium (inclusive of Taxes) for 2 year policy – ₹20,000
 (Premium indicated here is just for illustration purposes and may not be the actual premium.)

Policy Year	Transaction Date	Particulars of Healthy Reward Points (HRP) Earned/ Utilized by Insured	HRP - Opening Balance/ Balance Brought Forward during the Policy Period	HRP (earned/ utilized) on Transaction Date during the Policy Period	HRP - Closing Balance
1	1 Jan, 2021	Reward points equivalent to 1% of premium paid including taxes	0	200	200
1	20 Jan, 2021	Completion of Health Risk Assessment (HRA) and Targeted Risk Assessment (TRA) during the Policy Period. Rewards equivalent to 2.5% of premium paid inclusive of taxes.	200	500	700
1	10 Sep, 2021	Completion of enrolled Lifestyle Management Program (LMP) during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	700	600	1300
2	20 Mar, 2022	Completion of enrolled Chronic Condition Management Program during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	1300	600	1900
2	23 May, 2022	Participating in a ManipalCigna Sponsored Program – Total of 5 Programs during the Policy Period. Rewards equivalent to 10% (2% each per Program) of premium paid inclusive of taxes.	1900	2000	3900

2	28 Jul, 2022	Health Check-Up. Rewards equivalent to 0.5% of premium paid inclusive of taxes.	3900	100	4000*
<p>*Maximum reward that can be earned in a Policy Period is up to 20% of the premium paid including taxes. In this case, the maximum limit of 4000 (₹20000*20%) is achieved. Hence there shall not be any further earning of Healthy Rewards. However, earned reward points can be redeemed in the following ways - Against payable premium (including Taxes) from 1st Renewal of the Policy. - Equivalent value of Health Maintenance Benefit anytime during the Policy. As equivalent value while availing services through our Network Providers as defined in the Policy.</p>					
2	15 Oct, 2022	500 points – Redeemed as equivalent value in Health Maintenance Benefit, during the Policy Period	4000	-500	3500
2	1 Nov, 2022	1000 points – Redeemed as equivalent value for availing services through our Network Providers, during the Policy Period	3500	-1000	2500
2	31 Dec 2022	2500 points – Redeemed against payable renewal premium (including taxes) at the time of Renewal	2500	-2500	0
<p>Illustration 3 Policy details: Policy Type – Family Floater (2 Adults) Sum Insured – ₹5,50,000 Policy Period – 1 Year (Example: 1st Jan 2021 to 31st Dec 2021) Eldest Insured Age – 30 Years Premium (inclusive of Taxes) for 1 year policy – ₹10,000 (Premium indicated here is just for illustration purposes and may not be the actual premium.)</p>					
Policy Year	Transaction Date	Particulars of Healthy Reward Points (HRP) Earned/ Utilized by Insured	HRP - Opening Balance/ Balance Brought Forward during the Policy Period	HRP (earned/ utilized) on Transaction Date during the Policy Period	HRP - Closing Balance
1	1 Jan, 2021	Reward points equivalent to 1% of premium paid including taxes	0	100	100

1	20 Jan, 2021	Completion of Health Risk Assessment (HRA) and Targeted Risk Assessment (TRA) by Insured 1, during the Policy Period. Rewards equivalent to 2.5% of premium paid inclusive of taxes.	100	250	350
1	22 Jan, 2021	Completion of Health Risk Assessment (HRA) and Targeted Risk Assessment (TRA) by Insured 2, during the Policy Period. Rewards equivalent to 2.5% of premium paid inclusive of taxes.	350	250	600
1	10 Sep, 2021	Completion of enrolled Lifestyle Management Program (LMP) by Insured 1, during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	600	300	900
1	10 Sep, 2021	Completion of enrolled Lifestyle Management Program (LMP) by Insured 2, during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	900	300	1200
1	20 Sep, 2021	Completion of enrolled Chronic Condition Management Program by Insured 1, during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	1200	300	1500

1	20 Sep, 2021	Completion of enrolled Chronic Condition Management Program by Insured 2, during the Policy Period. Rewards equivalent to 3% of premium paid inclusive of taxes.	1500	300	1800
1	23 Sep, 2021	Participation in one of the ManipalCigna Sponsored Programs by Insured 1 – Total of 1 Program during the Policy Period. Rewards equivalent to 2% of premium paid inclusive of taxes.	1800	200	2000*
1	28 Sep, 2021	Health Check-Up. Rewards equivalent to 0.5% of premium paid inclusive of taxes.	2000*	0*	2000*

1	31 Dec 2021	1200 points – Redeemed against payable renewal premium (including taxes) at the time of Renewal	1200	-1200	0
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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. Hospital Daily Cash Benefit

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

- i. The hospitalization claim is admissible under the Base cover.
- ii. The Benefit will be available up to the maximum 30 days per Policy Year.
- iii. The Benefit under this cover will be over and above the Sum Insured under Section D.I.

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

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

D.III.2. Deductible

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

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

For the purpose of calculating the deductible and assessment of admissibility all claims must be submitted in accordance with Section G.I.16 of Claims Process.

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

Waiver of Deductible

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

- Opt out of deductible Within 48 Months

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

- Opt out of deductible After 48 Months

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

D.III.3. Reduction in Maternity Waiting Period

We will provide for a waiver of waiting period for Maternity Expenses (Section D.I.12) from 48 months to 24 months from the date of inception

*Maximum reward that can be earned in a Policy Period is up to 20% of the premium paid including taxes. In this case, the maximum limit of 2000 (₹10000*20%) is achieved. Hence there shall not be any further earning of Healthy Rewards. However, earned reward points can be redeemed in the following ways
 - Against payable premium (including Taxes) from 1st Renewal of the Policy.
 - Equivalent value of Health Maintenance Benefit anytime during the Policy.
 - As equivalent value while availing services through our Network Providers as defined in the Policy.

1	15 Oct, 2021	500 points – Redeemed as equivalent value in Health Maintenance Benefit, by Insured 1, during the Policy Period	2000	-500	1500
1	1 Nov, 2021	300 points – Redeemed as equivalent value for availing services through our Network Providers, by Insured 2, during the Policy Period	1500	-300	1200

of first Policy with Us.

New Born Baby cover and first year vaccinations will follow reduction in waiting period under Maternity Expenses Cover

All other terms, conditions and exclusions under Maternity Expenses Cover (Section D.I.12) shall apply.

D.III.4. Voluntary Co-Pay

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

Co-pays shall apply to all sections other than Health Maintenance Benefit, Health Check-Ups, Hospital Daily Cash Benefit and the Critical Illness Add on (if opted).

Co-pay will be applied on the admissible claim amount. In case You have selected the Voluntary co-pay (Section D.III.4) and/or if You chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction.

D.III.5. Waiver of Mandatory Co-pay

We will provide an option to remove Mandatory co-pay which is applicable for persons Aged 65 years and above will be available on payment of additional premium.

D.III.6. Cumulative Bonus Booster

We will provide an option to increase the Sum Insured by 25% for each policy year up to a maximum of 200% of Sum Insured provided that the Policy is renewed with Us without a break.

- No cumulative bonus will be added if the Policy is not renewed with Us by the end of the Grace Period. The Cumulative Bonus will not be accumulated in excess of 200% of the Sum Insured under the current Policy with Us.
- Any earned Cumulative Bonus will not be reduced for claims made in the future. Wherever the earned Cumulative Bonus is used for payment of a claim during a particular Policy Year.
- In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section D.II.3 shall not be available, however all terms and conditions of the said section shall apply.
- This Cumulative bonus shall not be available for claims made for Maternity Expenses under Section D.I.12, New Born Baby Expenses Section D.I.13 and First Year Vaccinations Section D.I.14

E. Exclusions

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

E.I. Standard Exclusions

E.I.1. Pre-existing Disease - Code-Excl. 01

- a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of applicable months (24 months for Preferred, Premier plan/ 36 months for Plus, Accumulate plan, Protect plan) of continuous coverage after the date of inception of the first policy with us.
- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the policy after the expiry of Pre-existing disease waiting period for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

E.I.2. Specified disease/procedure Waiting Period - Code-E.I.2

- a. Expenses related to the treatment of the listed Conditions, surgeries/ treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This

exclusion shall not be applicable for claims arising due to an accident.

- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures:
 - i. Cataract,
 - ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
 - iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Oestoarthritis and Osteoposrosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral 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, Hemorrhoids and any abscess related to the anal region.
 - viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/ Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
 - ix. gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/ internal tumors / skin tumors, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases,
 - x. Any surgery of the genito-urinary system unless necessitated by malignancy.

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

E.I.3. 30 days Waiting Period - Code-E.I.3

- a) Expenses related to the treatment of any illness within 30 days of continuous coverage from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

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

- a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
 - a. greater than or equal to 40 or
 - b. greater than or equal to 35 in conjunction with any of the following severe comorbidities

following failure of less invasive methods of weight loss:

- i. Obesity-related cardiomyopathy
- ii. Coronary heart disease
- iii. Severe Sleep Apnea
- iv. Uncontrolled Type 2 Diabetes

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

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

E.I.8. Cosmetic or Plastic Surgery Code- Excl 08

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

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 health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code-Excl13

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:

- (i) Any type of contraception, sterilization
- (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- (iii) Gestational Surrogacy
- (iv) Reversal of sterilization

E.I.18. Maternity Code-Excl 18 (applicable to Protect and Accumulate plan)

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. 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. Maternity Waiting Period

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

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

E.II.2. Personal Waiting period

A special Waiting Period not exceeding 36 months, may be applied to individual Insured Persons for the list of acceptable Medical Ailments listed under Underwriting Manual of the Product depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

E.II.3. 90 day waiting period for Critical Illness Add On Cover (if opted)

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

E.II.4. Dental Treatment, orthodontic treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way, unless specifically covered under the Policy.

E.II.5. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

E.II.6. 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.7. External Congenital Anomaly or defects or any complications or conditions arising therefrom.

E.II.8. 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.9. 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.10. Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses.

E.II.11. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

E.II.12. Any form of Non-Allopathic treatment (except AYUSH Treatment), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

E.II.13. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack or in any other sequence to the loss.

E.II.14. All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

E.II.15. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment. For complete list of Non-medical expenses, please refer to the Annexure IV List - I "Items for which Coverage is not available in the Policy"

E.II.16. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.

E.II.17. Pre-existing condition disclosed by the Insured Person will be reviewed according to the company's underwriting policy.

E.III. Exclusion which can be opted for cover by payment of additional premium

E.III.1. Maternity Waiting Period

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

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

(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.3 of the Policy and limits as specified in the Policy Schedule)

F. General Terms and Clauses

F.I. Standard General Terms and Clauses

F.I.1. Disclosure of Information

a. The Policy shall be null and void, and all premium paid thereon shall be forfeited to the Company in the event of any misrepresentation or mis-description of any material fact by the policyholder.

b. The Policy shall be null and void, and all premium paid thereon shall be forfeited to the Company in the event of non-disclosure of any material fact by the policyholder.

("Material facts" for the purpose of this Policy shall mean all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

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

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

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

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

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

F.I.4. Complete Discharge

Any payment 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.5. Multiple Policies

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

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

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

F.I.6. Fraud

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

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

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

- a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

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

F.I.7. Cancellation

The policyholder may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

A. Policy Tenure of 1 Year:

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

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2024

Tenure	1
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	285
Premium Refund	77.87 (100*285/365)

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

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

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

B. If Policy Tenure is more than 1 years:

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

Illustration:

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

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

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

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

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

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

F.I.8. Migration

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

F.I.9. Portability

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

All benefits under the Policy will terminate on successful porting of the Policy other than any Health Maintenance Benefit under Accumulate Plan which will be available for a claim up to a period of 12 months from the date of expiry of such policy.

F.I.10. Renewal of Policy

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

- The Company shall give notice for renewal at least 30 days in advance from the Policy due date.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days, to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual claims experience.

F.I.11. Withdrawal of Policy

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

F.I.12. Moratorium Period

After completion of 60 continuous months of coverage (including Portability and Migration) in health insurance policy, no Policy and claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of 60 continuous 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. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

F.I.13. Premium Payment in Instalments (Wherever applicable)

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)

- i. 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.
- ii. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- iii. Instalment facility shall not be available for the Policy Tenure more than 1 year.
- iv. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- v. No interest will be charged if the instalment premium is not paid on due date.
- vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- viii. The company has the right to recover and deduct all the pending instalments, for the Policy Year, from the claim amount due under the policy.

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

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

F.I.15. Free Look period

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

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

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

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

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

F.I.16. Redressal of Grievance

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

Email: customercare@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

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

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

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

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

or

Email: headcustomercare@manipalcigna.com.

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

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the

office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

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

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

The office Name and address details applicable for your state can be obtained from - <https://www.cioins.co.in/Ombudsman>

F.I.17. Nomination

The policyholder is required at the inception of the policy 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.II. Specific terms and clauses

F.II.1. Material Change

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

F.II.2. Alterations in the Policy

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

F.II.3. Change of Policyholder

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

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

F.II.4. 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.5. 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.6. Mandatory Co-pay

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

Co-pay will be applied on the admissible claim amount. In case the Insured has selected the Voluntary co-pay (Section D.III.4), and/or if he chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction.

F.II.7. Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all medical records pertaining to claim and shall allow Us or our representative (s) to inspect such records. You or the Insured

Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

F.II.8. Grace Period

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

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. 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. In case of Accumulate Plan only the unutilised Health Maintenance Benefit limit (excluding any Cumulative Bonus) will be available for a claim during the grace period
- c. Where the Policy is not renewed before the end of the Grace Period and the Policy is terminated, any unutilized Health Maintenance Benefit limit in respect of the Accumulate Plan shall be available for a claim as defined under Section D.I.11 above up to a period of 12 months from the date of expiry of the Policy. All Such claims will be in respect of the Insured Members under the expiring policy only.
- d. Renewals will not be denied except on grounds of misrepresentation, established fraud, non-disclosure of material facts by You.
- e. Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy.
- f. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.
- g. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.
- h. Alterations like increase/decrease in Sum Insured or Change in Plan/ Product, addition/deletion of members, addition/deletion of optional covers/riders, addition addition deletion of Medical Condition existing prior to policy inception will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for change of Sum Insured on renewal. The terms and conditions of the existing policy will not be altered.
- i. Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
- j. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 36/ 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.
- k. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section E.I.1 to E.I.3 and E.II.1 and E.II.2 will be applicable considering such Policy Year as the first year of Policy with the Company.
- l. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.
- m. Once an Insured Person attain age of 65 years on renewal a Mandatory co-payment of 20% will be applicable on all claims irrespective of the age of entry in to the Policy. This clause does not apply to persons who have opted for a Waiver of Mandatory Co-pay.
- n. In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover,

however all continuity benefits on the policy will remain intact. Cumulative Bonus earned on the Policy will stay with the floater cover.

III. 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 of 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.

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

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

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

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

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

Zone Classification

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

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

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

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

- (a) Persons paying Zone I premium can avail treatment all over India without any Co-pay.
- (b) Persons paying Zone II premium
 - i) Can avail treatment in Zone II and Zone III without any Co-pay.
 - ii) Availing treatment in Zone I will have to bear 10% of each and every claim.
- (c) Person paying Zone III premium
 - i) Can avail treatment in Zone III, without any Co-pay.
 - ii) Availing treatment in Zone II will have to bear 10% of each and every claim.
 - iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

***Option to select a Zone higher or lower than that of the actual Zone is available on payment of applicable premium at the time of buying the First Policy and on subsequent renewals

Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalization due to Accident. The aforesaid Co-payments applicable are in addition to the Voluntary Co-pay under Section D.III.3 (if opted) and Mandatory Co-pay under Section D.III.5 (if applicable) and will be applied in conjunction to Section D.III.4 and

Section D.III.5 of the Policy.

F.II.11. Discounts under the Policy

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

- Family Discount** - A discount of 25% for Protect and Plus Plan and 10% for Preferred, Premier and Accumulate Plans covering 2 and more family members under the same policy under the individual policy option.
- Long Term policy discount** - Long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy.
- Worksite Marketing Discount** - A discount of 10% will be available on policies which are sourced through worksite marketing channel.
- Voluntary Co-pay Discount** - A discount of 7.5% for opting 10% Co-pay and a discount of 15% for opting a 20% Co-pay on the Policy in case of Protect & Plus Plan.

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

Discount under F.II.11. (a) is applicable only to individual policies. All discounts under F.II.11. (b) to (d) are available to both individual as well as floater policies. Maximum discount applicable on a single policy shall not exceed 40%, excluding discount for Voluntary Co-pay which is a cost sharing mechanism.

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

F.II.12. Loadings & Special Conditions

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.

We may apply a specific sub-limit on a medical condition/ailment depending on the past history and declarations or additional waiting periods (a maximum of 36 months from the date of inception of first policy) 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 premium, within the duration specified in the counter offer letter.

F.II.13. Communications & Notices

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

- The policyholder's, at the address as specified in Schedule
- To Us, at the address specified in the Schedule.
- 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.
- 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.14. Electronic Transactions

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

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

All terms and conditions in respect of Electronic Transactions shall be

within the approved Terms and Conditions of the Policy.

F.II.15. 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.16. Terms and conditions of the Policy

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

F.II.17. Dispute Resolution

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

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

G.I.2. 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:

- Forthwith intimate, file and submit the Claim in accordance to the Claim Procedure defined under Section G.I.3, G.I.4, and G.I.5 as mentioned below.
- 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.
- Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- 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 48 hours prior to the planned date of admission.
- Emergency Hospitalization, You /the Insured Person will intimate such admission within 24 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 or Common empanelment of hospital/healthcare providers as specified by Insurance Council. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital or Common empanelment of hospital/healthcare providers as specified by Insurance Council, 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:

- The Insured Person should at least 48 hours prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.
- The Network Provider or common empanelment of hospital/healthcare providers will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDA.
- The Network Provider or common empanelment of hospital/healthcare providers shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty four) hour authorization/cashless department along with contact details of the treating Medical Practitioner and the Insured Person.
- Upon receiving the pre-authorization form and all related medical information from the Network Provider or common empanelment of hospital/healthcare providers, We will verify the eligibility of cover under the Policy.
- Wherever the information provided in the request is sufficient to ascertain the authorisation We shall issue the authorisation Letter to the Network Provider or common empanelment of hospital/healthcare providers. Wherever additional information or documents are required We will call for the same from the Network provider or common empanelment of hospital/healthcare providers and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 1 hour from the receipt of last complete documents.
- The Authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any co-pays or deductibles and non-payable items if applicable.
- 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:

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

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

At the time of discharge:

- The Network Provider or hospital/healthcare providers of common empanelment may forward a final request for authorization for any residual amount to us along with the discharge summary and the billing

format in accordance with the process described at G.I.4.(a) above.

- We shall accept or decline such additional expenses within 3 (Three) hours of receiving the complete documents for final discharge from Network provider or Common empanelment of hospital/healthcare providers.
- Upon receipt of the final authorisation letter from us, You may be discharged by the Network Provider.

(b) In case of Emergency Hospitalization

- The Insured Person may approach the Network Provider or common empanelment of hospital/healthcare providers for Hospitalization for medical treatment.
- The Network Provider or common empanelment of hospital/healthcare providers shall forward the request for authorization within 24 hours of admission to the Hospital as per the process under Section G.I.4 (a).
- 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.
- In the interim, the Network Provider or common empanelment of hospital /healthcare providers may either consider treating the Insured Person by taking a token deposit or treating him as per their norms in the event of any lifesaving, limb saving, sight saving, Emergency medical attention requiring situation.
- The Network Provider or common empanelment of hospital/healthcare providers shall refund the deposit amount to You barring a token amount to take care of non-covered expenses once the pre-authorization is issued.

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

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

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

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

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

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

G.I.5. Claim Reimbursement Process

(a) Collection of Claim Documents

- 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 <https://www.manipalcigna.com/downloads/claims>

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

Claim form duly signed
Copy of photo ID of patient
Hospital Discharge summary
Operation Theatre notes
Hospital Main Bill
Hospital Break up bill
Investigation reports
Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Doctors reference slip for investigation
Pharmacy Bills
MLC/ FIR report, Post Mortem Report if applicable and conducted
KYC documents (Photo ID proof, address proof, recent passport size photograph)
Cancelled cheque for NEFT payment
Payment receipt.

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

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

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

G.I.7. Claim Assessment

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

a) For Plans without Deductible Option

- i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned on pro rata basis. Such apportioned amount will apply to all "Associated Medical Expenses". [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)]
- ii) Any Voluntary, Mandatory or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7 a (i)

b) For Plans with Deductible Option

- i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned on pro rata basis. Such apportioned amount will apply to all "Associated Medical

Expenses". [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses]]

- ii) Arrived payable claim amount will be assessed against the deductible.
- iii) Any Mandatory or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7 b (i), (ii)
- c) The Claim amount assessed under Section G.I.7 a) and b) will be deducted from the following amounts in the following progressive order-
 - i) Deductible & Co-pays (if opted)
 - ii) Mandatory Copays (if applicable)
 - iii) Zonal Copays (if applicable)
 - iv) Sum Insured
 - v) Cumulative Bonus
 - vi) Restored Sum Insured

Claim Assessment for Benefit Plans:

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

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

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

G.I.8. Claims Investigation

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

G.I.9. Pre 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 Plan shall be reduced by the amount payable / paid under the Benefit (s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.

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

For Cashless Claims, the payment shall be made to the Network Hospital or common empanelment of hospital/healthcare providers 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 Maintenance Benefit

- (a) Submission of claim

You can send the Health Maintenance Benefit claim form along with the

invoices, treating Medical Practitioner's prescription, reports, duly signed by You/ Insured Person as the case may be, to Our branch office or Head Office at your own expense. The Health Maintenance Benefit under all Plans can be claimed only once during the Policy Period up to the extent of limit under this benefit or a maximum of ₹15000.

Where a claim for Health Maintenance Benefit exceeds ₹ 15,000 for a single claim the same can be claimed at any time during the Policy Period.

In respect of Health Maintenance Benefit under the Accumulate Plan which is utilised for payment of opted Deductible or Co-pay the same can be settled along with the claim under the respective sections wherever applicable.

(b) Assessment of Claim Documents

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

(c) Settlement & Repudiation of a claim

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

G.I.13. Expert Opinion on Critical Illness

(a) Receive Request for Expert Opinion on Critical Illness

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

(b) Facilitating the Process

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

G.I.14 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.

G.I.15. 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 of the Policy.

G.I.16. 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)
- b) Wherever such hospitalization claims as stated under G.I.16. 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.17. Application of Multiple policies clause

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

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

- i) **Cashless hospitalization:** In case the Insured avail Cashless Facility for Hospitalization then Insured or Network Provider or common empanelment of hospital/healthcare providers will intimate us of the admission through a pre-authorisation request with all details & estimated amount for the Hospitalization. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy/policies so chosen. The

Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies

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

b) Retail policy & group policy from the Company:

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

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

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

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

G.II . Annexure – I:

Ombudsman

The contact details of the Insurance Ombudsman offices are as below:

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
<p>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</p>	<p>State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.</p>
<p>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</p>	<p>State of Karnataka.</p>
<p>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 / 2769202 Email: bimalokpal.bhopal@cioins.co.in</p>	<p>States of Madhya Pradesh and Chhattisgarh.</p>
<p>BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar - 751 009. Tel.:- 0674-2596461/2596455 Email: bimalokpal.bhubaneswar@cioins.co.in</p>	<p>State of Orissa.</p>
<p>CHANDIGARH Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh - 160 017 Tel.:- 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in</p>	<p>States of Punjab, Haryana, (excluding 4 districts viz Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.</p>
<p>CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI - 600 018. Tel.:- 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in</p>	<p>State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).</p>
<p>DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.:- 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in</p>	<p>Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonapat and Bahadurgarh</p>
<p>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</p>	<p>States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.</p>
<p>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 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in</p>	<p>State of Andhra Pradesh, Telangana and Yanam - a part of Territory of Puducherry.</p>

<p>JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in</p>	<p>State of Rajasthan.</p>
<p>KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in</p>	<p>States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Puducherry.</p>
<p>KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. TEL : 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in</p>	<p>States of West Bengal, Sikkim, and Union Territories of Andaman and Nicobar Islands.</p>
<p>LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in</p>	<p><u>Districts of Uttar Pradesh</u> 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.</p>
<p>MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in</p>	<p>State of Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai and Thane</p>
<p>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</p>	<p>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.</p>
<p>PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in</p>	<p>States of Bihar and Jharkhand.</p>
<p>PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in</p>	<p>States of Maharashtra, Areas of Navi Mumbai and Thane but excluding Mumbai Metropolitan.</p>

G.III. Annexure-II:

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

Microsurgical Operations on the middle ear

1. Stapedotomy to treat various lesions in the middle ear
2. Revision of Stapedotomy
3. Other operations of the auditory ossicles
4. Myringoplasty (post-aural/ 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 Paracentesis/ Cyclotherapy/ 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 NailBed

Operations on the tongue

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

Operations on the salivary glands & salivary ducts

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

Other operations on the mouth & face

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

Operations on tonsils and adenoids

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

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, duodenoscopy 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. Therapeutic 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. Salpingo-Oophorectomy via Laparoscopy
120. Hysteroscopic removal of myoma
121. D&C
122. Hysteroscopic resection of septum
123. Thermal cauterisation of cervix
124. Mirena insertion
125. Hysteroscopic adhesiolysis
126. LEEP (loop electrosurgical excision procedure)
127. Cryocauterisation of cervix
128. Polypectomy endometrium
129. Hysteroscopic resection of fibroid
130. LLETZ (large loop excision of transformation zone)
131. Conization
132. Polypectomy cervix
133. Hysteroscopic resection of endometrial polyp
134. Vulval wart excision
135. Laparoscopic paraovarian CYST excision
136. Uterine artery embolization
137. Laparoscopic cystectomy
138. Hymenectomy(imperforate hymen)
139. Endometrial ablation
140. Vaginal wall cyst excision
141. Vulval cyst excision
142. Laparoscopic paratubal CYST excision
143. Repair of vagina (vaginal atresia)
144. Hysteroscopy, removal of myoma
145. Ureterocele repair-congenital internal
146. TURBT
147. Vaginal mesh for POP
148. Laparoscopic myomectomy
149. Surgery for SUI
150. Repair recto-vagina fistula
151. Pelvic floor repair (excluding fistula repair)
152. URS + II
153. Laparoscopic oophorectomy
154. Normal vaginal delivery & variants
- Operations on the prostate & seminal vesicles**
155. Incision of the prostate
156. Transurethral excision and destruction of prostate tissue
157. Transurethral and percutaneous destruction of prostate tissue
158. Open surgical excision and destruction of prostate tissue
159. Radical prostatovesiculectomy
160. Other excision and destruction of prostate tissue
161. Operations on the seminal vesicles
162. Incision and excision of periprostatic tissue
163. Other operations on the prostate
- Operations on the scrotum & tunica vaginalis testis**
164. Incision of the scrotum and tunica vaginalis testis
165. Operation on a testicular hydrocele
166. Excision and destruction of diseased scrotal tissue
167. Other operations on the scrotum and tunica vaginalis testis
- Operations on the testes**
168. Incision of the testes
169. Excision and destruction of diseased tissue of the testes
170. Unilateral orchidectomy
171. Bilateral orchidectomy
172. Orchidopexy
173. Abdominal exploration in cryptorchidism
174. Surgical repositioning of an abdominal testis
175. Reconstruction of the testis
176. Implantation, exchange and removal of a testicular prosthesis
177. Other operations on the testes
- Operations on the spermatic cord, epididymis and ductus deferens**
178. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
179. Excision in the area of the epididymis
180. Epididymectomy
- Operations on the penis**
181. Operations on the foreskin
182. Local excision and destruction of diseased tissue of the penis
183. Amputation of the penis
184. Other operations on the penis
- Operations on the urinary system**
185. Cystoscopic removal of stones
186. Catheterisation of bladder
- Other Operations**
187. Lithotripsy
188. Coronary angiography
189. Biopsy of Temporal Artery for Various lesions
190. External Arterio-venous shunt
191. Haemodialysis
192. Radiotherapy for Cancer
193. Cancer Chemotherapy
194. Endoscopic polypectomy
- Operation of bone and joints**
195. Surgery for ligament tear
196. Surgery for meniscus tear
197. Surgery for hemoarthrosis/ pyoarthrosis
198. Removal of fracture pins/ nails
199. Removal of metal wire
200. Closed reduction on fracture, luxation
201. Reduction of dislocation under GA
202. Epiphyseolysis with osteosynthesis
203. Excision of Bursitis
204. Tennis elbow release
205. Excision of various lesions in Coccyx
206. Arthroscopic knee aspiration
207. Surgery for meniscus tear
208. Arthroscopic repair of ACL tear KNEE
209. Closed reduction of minor fractures

210. Arthroscopic repair of PCL tear KNEE
211. Tendon shortening
212. Arthroscopic meniscectomy - KNEE
213. Treatment of clavicle dislocation
214. Haemarthrosis KNEE- lavage
215. Abscess KNEE joint drainage
216. Carpal tunnel release
217. Closed reduction of minor dislocation
218. Repair of KNEE cap tendon
219. ORIF with K wire fixation- small bones
220. Release of midfoot joint
221. ORIF with plating- small long bones
222. Implant removal minor
223. K wire removal
224. POP application
225. Closed reduction and external fixation
226. Arthrotomy hip joint
227. Syme's amputation
228. Arthroplasty
229. Partial removal of RIB
230. Treatment of sesamoid bone fracture
231. Shoulder arthroscopy / surgery
232. Elbow arthroscopy
233. Amputation of metacarpal bone
234. Release of thumb contracture
235. Incision of foot fascia
236. Calcaneum SPUR hydrocort injection
237. Ganglion wrist hyalase injection
238. Partial removal of metatarsal
239. Repair / graft of foot tendon
240. Revision/removal of knee cap
241. Amputation follow-up surgery
242. Exploration of ankle joint
243. Remove/graft leg bone lesion
244. Repair/graft achilles tendon
245. Remove of tissue expander
246. Biopsy elbow joint lining
247. Removal of wrist prosthesis
248. Biopsy finger joint lining
249. Tendon lengthening
250. Treatment of shoulder dislocation
251. Lengthening of hand tendon
252. Removal of elbow bursa
253. Fixation of knee joint
254. Treatment of foot dislocation
255. Surgery of bunion
256. Intra articular steroid injection
257. Tendon transfer procedure
258. Removal of knee cap bursa
259. Treatment of fracture of ULNA
260. Treatment of scapula fracture
261. Removal of tumor of arm/ elbow under RA/GA
262. Repair of ruptured tendon
263. Decompress forearm space
264. Revision of neck muscle (torticollis release)
265. Lengthening of thigh tendons
266. Treatment fracture of radius & ulna
267. Repair of knee joint
- Critical Care Related:**
268. Insert Non-Tunnel CV cath
269. Insert PICC cath (Peripherally Inserted Central Catheter)
270. Insertion Catheter, Intra Anterior
271. Replace PICC cath (Peripherally Inserted Central Catheter)
272. Insertion of Portacath
- Dental Related:**
273. Splinting of avulsed teeth
274. Suturing lacerated lip
275. Suturing oral mucosa
276. Oral biopsy in case of abnormal tissue presentation
277. FNAC
278. Smear from oral cavity
- ENT Related:**
280. Myringotomy with grommet insertion
281. Keratosis removal under GA
282. Adenoidectomy
283. Labyrinthectomy for severe vertigo
284. Stapedectomy under GA
285. Stapedectomy under LA
286. Tympanoplasty (type - IV)
287. Endolymphatic sac surgery for meniere's disease
288. Turbinectomy
289. Endoscopic stapedectomy
290. Incision and drainage of perichondritis
291. Septoplasty
292. Vestibular nerve section
293. Thyroplasty type - I
294. Pseudocyst of the pinna - excision
295. Incision and drainage - haematoma auricle
296. Tympanoplasty (type - II)
297. Reduction of fracture of nasal bone
298. Thyroplasty type - II
299. Tracheostomy
300. Excision of angioma septum
301. Turbinoplasty
302. Incision & drainage of retro pharyngeal abscess
303. UVULO palato pharyngo plasty
304. Adenoidectomy with grommet insertion
305. Adenoidectomy without grommet insertion
306. Vocal cord lateralisation procedure
307. Incision & drainage of para pharyngeal abscess
308. Tracheoplasty
- Gastroenterology Related**
309. Pancreatic pseudocyst EUS & drainage
310. RF ablation for barrett's oesophagus
311. ERCP and papillotomy
312. Esophagoscope and sclerosant injection
313. EUS + submucosal resection
314. Construction of gastrostomy tube
315. EUS + aspiration pancreatic CYST
316. Small bowel endoscopy (therapeutic)
317. Colonoscopy, lesion removal
318. ERCP
319. Percutaneous endoscopic gastrostomy
320. EUS and pancreatic pseudo CYST drainage
321. ERCP and choledochoscopy
322. Proctosigmoidoscopy volvulus detorsion
323. ERCP and sphincterotomy
324. Esophageal stent placement
325. ERCP + placement of biliary stents
326. Sigmoidoscopy W / stent
327. EUS + coeliac node biopsy
328. UGI scopy and injection of adrenaline, sclerosants bleeding ulcers

General Surgery Related:

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

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

Neurology Related:

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

Oncology Related:

435. IV push chemotherapy
436. HBI-hemibody radiotherapy
437. Infusional targeted therapy
438. SRT-stereotactic arc therapy
439. SC administration of growth factors
440. Continuous infusional chemotherapy
441. Infusional chemotherapy
442. CCRT - concurrent chemo + RT
443. 2D radiotherapy
444. 3D conformal radiotherapy
445. IGRT - image guided radiotherapy
446. IMRT- step & shoot
447. Infusional bisphosphonates

- 448. IMRT - DMLC
- 449. Rotational ARC therapy
- 450. Tele gamma therapy
- 451. FSRT-fractionated SRT
- 452. VMAT-volumetric modulated arc therapy
- 453. SBRT-stereotactic body radiotherapy
- 454. Helical tomotherapy
- 455. SRS-stereotactic radiosurgery
- 456. X-knife SRS
- 457. Gammaknife SRS
- 458. TBI-total body radiotherapy
- 459. Intraluminal brachytherapy
- 460. Electron therapy
- 461. TSET-total electron skin therapy
- 462. Extracorporeal irradiation of blood products
- 463. Telecobalt therapy
- 464. Telecesium therapy
- 465. External mould brachytherapy
- 466. Interstitial brachytherapy
- 467. Intracavity brachytherapy
- 468. 3D brachytherapy
- 469. Implant brachytherapy
- 470. Intravesical brachytherapy
- 471. Adjuvant radiotherapy
- 472. Afterloading catheter brachytherapy
- 473. Conditioning radiotherapy for BMT
- 474. Extracorporeal irradiation to the homologous bone grafts
- 475. Radical chemotherapy
- 476. Neoadjuvant radiotherapy
- 477. LDR brachytherapy
- 478. Palliative radiotherapy
- 479. Radical radiotherapy
- 480. Palliative chemotherapy
- 481. Template brachytherapy
- 482. Neoadjuvant chemotherapy
- 483. Adjuvant chemotherapy
- 484. Induction chemotherapy
- 485. Consolidation chemotherapy
- 486. Maintenance chemotherapy
- 487. HDR brachytherapy

Operations on the Tongue:

- 488. Small reconstruction of the tongue

Ophthalmology related:

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

Plastic surgery related: mouth & face:

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

Thoracic surgery related:

- 504. Thoracoscopy and lung biopsy
- 505. Excision of cervical sympathetic chain thoracoscopic

- 506. Laser ablation of barrett's oesophagus
- 507. Pleurodesis
- 508. Thoracoscopy and pleural biopsy
- 509. EBUS + biopsy
- 510. Thoracoscopy ligation thoracic duct
- 511. Thoracoscopy assisted empyaema drainage

Urology related:

- 512. Biopsy of temporal artery for various lesions
- 513. AV fistula-wrist
- 514. URSL with stenting
- 515. URSL with lithotripsy
- 516. Cystoscopic litholapaxy
- 517. ESWL
- 518. Bladder neck incision
- 519. Cystoscopy & biopsy
- 520. AV fistula-wrist
- 521. Cystoscopy and removal of polyp
- 522. Suprapubic cystostomy
- 523. Percutaneous nephrostomy
- 524. Cystoscopy and "sling" procedure
- 525. Tuna-prostate
- 526. Excision of urethral diverticulum
- 527. Removal of urethral stone
- 528. Excision of urethral prolapse
- 529. Mega-ureter reconstruction
- 530. Kidney renoscopy and biopsy
- 531. Ureter endoscopy and treatment
- 532. Vesico ureteric reflux correction
- 533. Surgery for pelvi ureteric junction obstruction
- 534. Anderson hynes operation (open pyelopalsty)
- 535. Kidney endoscopy and biopsy
- 536. Paraphimosis surgery
- 537. Injury prepuce-circumcision
- 538. Frenular tear repair
- 539. Meatotomy for meatal stenosis
- 540. Surgery for fournier's gangrene scrotum
- 541. Surgery filarial scrotum
- 542. Surgery for watering CAN perineum
- 543. Repair of penile torsion
- 544. Drainage of prostate abscess
- 545. Orchiectomy
- 546. Cystoscopy and removal of FB

G.IV. Annexure - III:

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief					
Your Coverage Details:	Identify your Plan	Protect	Plus	Preferred	Premier	Accumulate
Basic Cover This section lists the Basic benefits available on your plan	Identify your Opted Sum Insured	₹2.5 Lacs, ₹3.5 Lacs, ₹4.5 Lacs, ₹5.5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹50 Lacs	₹4.5 Lacs, ₹5.5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹50 Lacs	₹15 Lacs, ₹30 Lacs, ₹50 Lacs	₹100 Lacs	₹5.5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹50 Lacs
	Inpatient Hospitalization (When you are hospitalized)	For Sum Insured up to ₹5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category	Covered up to any Room Category except Suite or higher category			For Sum Insured ₹5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category
	Pre-hospitalization	Medical Expenses Covered up to 60 days before date of hospitalization				
	Post-hospitalization	Medical Expenses Covered up to 90 days post discharge from hospital	Medical Expenses Covered up to 180 days post discharge from hospital			Covered up to 90 days post discharge from hospital
	Day Care Treatment	Covered up to the limit of Sum Insured opted				
	Domiciliary Treatment (Treatment at Home)	Covered up to the limit of Sum Insured opted				
	Ambulance Cover (Reimbursement of Ambulance Expenses)	Up to ₹2000 paid per Hospitalization event	Up to ₹3000 paid per Hospitalization event	Actual incurred expenses paid per Hospitalization event		Up to ₹2000 per Hospitalization event
	Donor Expenses (Hospitalization Expenses of the donor providing the organ)	Covered up to full Sum Insured				
	Worldwide Emergency Cover (Outside India)	Covered up to full Sum Insured once in a Policy Year				
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for unrelated illnesses in addition to the Sum Insured opted				
	AYUSH Cover	Covered up to full Sum Insured				
	Health Maintenance Benefit (Treatment that does not require Hospitalization and can be carried out in an Out Patient Department)	Covered up to ₹500 Per policy Year	Covered up to ₹2000 Per policy Year	Covered up to ₹15000 per policy year.		Option to choose from - ₹5000, ₹10000, ₹15000, ₹20000 Per policy Year Can also be used to pay for Co-pay or Deductible. Up to 50 % of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy

	Cumulative Bonus on Health Maintenance Benefit	NA	NA	NA	5% Cumulative Bonus on the unutilized Health Maintenance Benefit limit (HMB) available at the end of the Policy Year irrespective of whether a claim is made on the expiring policy.	
	Maternity Expenses	Not Available	Covered upto ₹15,000 for normal delivery and ₹25,000 for C-Section per event, after a Waiting Period of 48 months	Covered upto ₹50,000 for normal delivery and ₹100,000 for C-Section per event, after a waiting Period of 48 months	Covered upto ₹100,000 for normal delivery and ₹200,000 for C-Section per event, after a waiting Period of 48 months	Not Available
	New Born Baby Expenses		Covered for the inpatient hospitalization expenses of a new born up to the limit provided under Maternity Expenses			
	First Year Vaccinations		Covered as per national immunization programme over and above Maternity Sum Insured			
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Health Check-Up	Available once every 3 rd Policy year to all insured persons who have completed 18 years of Age	Available each policy year (excluding the first year), to all insured persons who have completed 18 years of Age			Available once every 3 rd Policy year to all insured persons who have completed 18 years of Age
	Expert Opinion on Critical illness (By a Specialist)	Available once during the Policy Year				
	Cumulative Bonus	A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.	A guaranteed 10% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured			A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.
	Healthy Rewards	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used against payable premium (including Taxes) from 1 st Renewal of the Policy. OR they can be redeemed for equivalent value of Health Maintenance Benefits any time during the policy OR as equivalent value while availing services through our Network Providers as defined in the policy.				
Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Hospital Daily Cash Benefit	₹1000 for each continuous and completed 24 Hours of Hospitalization during the Policy Year up to a maximum of 30 days in a policy year	₹2000 for each continuous and completed 24 Hours of Hospitalization during the Policy Year up to a maximum of 30 days in a policy year	₹3000 for each continuous and completed 24 Hours of Hospitalization during the Policy Year up to a maximum of 30 days in a policy year		₹1000 for each continuous and completed 24 Hours of Hospitalization during the Policy Year up to a maximum of 30 days in a policy year
	Deductible (Please select the Sum Insured and Deductible amount as you have opted on the Policy. Deductible is the amount beyond which a claim will be payable in the Policy)	₹1/ 2/ 3/ 4/ 5/ 7.5 /10 Lacs	₹1/ 2/ 3/ 4 / 5/ 7.5 / 10 Lacs	Not Available		₹0.5/1/ 2/ 3/ 4/ 5/ 7.5 / 10 Lacs
	Waiver of Deductible:	Available	Available	Not Available		Available
	Reduction in Maternity Waiting Period	Not Available	Maternity waiting period Reduced from 48 months to 24 months			Not Available

	<p>Voluntary Co-pay (The cost sharing percentage that you have opted will apply on each claim.) If you have opted for a Deductible, Voluntary Co-payment does not apply</p>	10% or 20% Voluntary Co-payment for each and every claim as opted	Not Available	10% or 20% voluntary co-payment for each and every claim as opted on the Policy
	Waiver of Mandatory Co-pay	Waiver of Mandatory co-payment of 20% for Insured Persons Aged 65 years and above		
	Cumulative Bonus booster	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured	Not Available	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured
<p>Add on cover (Rider) This section lists the Add on cover available under your plan</p>	ManipalCigna Critical Illness	Lump sum payment of an additional 100% of Sum Insured Opted	Not Available	Lump sum payment of an additional 100% of Sum Insured Opted
	ManipalCigna Health 360	Shield: Coverage for listed Non-medical items and durable medical equipment		
		Advance: Coverage for 'Any room' category and unlimited restoration of Sum Insured. It also provides Air Ambulance cover, over and above the base policy Sum Insured		
		<p>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.</p>		
	ManipalCigna Prime Plus	<p>1. Room Rent Modification: The Insured Person shall be eligible to modify the room type category eligibility under the Policy to Twin Sharing AC room and ICU Up to Sum Insured.</p> <p>2. Supreme Bonus: Guaranteed Cumulative Bonus of 100% of Base Sum Insured each policy year; subject to a maximum of 800% of the Base Sum Insured.</p> <p>Note: Applicable with Sum Insured ₹5 Lacs and above up to ₹50 Lacs of the Underlying Policy .</p> <p>3. Deductible: Option to opt from ₹10,000 and ₹25,000 on aggregate basis.</p>	Not Available	

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

**Supreme Bonus can be opted only when Cumulative Bonus Booster optional cover is not opted.

You are advised to refer to the attached Customer Information Sheet (CIS) for summary of benefits available in the Policy Wordings.

G.V. Annexure - IV

List I - Items for which Coverage is not available in the Policy (This list is not applicable for claims under Health Maintenance Benefit)

Sl. No.	Item
1.	BABY FOOD
2.	BABY UTILITIES CHARGES
3.	BEAUTY SERVICES
4.	BELTS / BRACES
5.	BUDS
6.	COLD PACK / HOT PACK
7.	CARRY BAGS
8.	EMAIL I INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVEYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR

45.	KNEE BRACES (LONG / SHORT / HINGED)
46.	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53.	SUGAR FREE Tablets
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

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

Sl. No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE I ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES

24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET / WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES I ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS I VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES I MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND I NAME TAG
37.	PULSEOXYMETER CHARGES
List III - Items that are to be subsumed into Procedure Charges	
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	
Sl. No.	Item
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 / CAPO EQUIPMENTS
7.	INFUSION PUMP - COST
8.	HYDROGEN PEROXIDE \SPIRIT \ DISINFECTANTS ETC
9.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10.	HIV KIT
11.	ANTISEPTIC MOUTHWASH
12.	LOZENGES
13.	MOUTH PAINT
14.	VACCINATION CHARGES
15.	ALCOHOL SWABES
16.	SCRUB SOLUTIONISTERILLIUM
17.	GLUCOMETER & STRIPS
18.	URINE BAG