Manipal Cigna Health Insurance

MANIPALCIGNA SARVAH - UTTAM

POLICY CONTRACT

B. Preamble

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

If any claim arises as a result of an illness or injury that occurred during the Policy Period and becomes payable, we shall pay the benefits in accordance with the terms, conditions, and exclusions of the Policy, subject to the availability of the Sum Insured and the Guaranteed Cumulative Bonus (Gullak if opted and earned). 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:
   1) Central or State Government AYUSH Hospital; or
   2) Teaching hospitals attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
   3) AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i) having at least five In-patient beds;
      ii) having qualified AYUSH Medical Practitioner in charge round the clock;
      iii) having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv) maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

5. **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/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

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 or common empaneled Hospital/healthcare providers by the insurer to the extent pre-authorization approved.

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

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

10. **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.

11. **Cumulative Bonus** means any increase or addition in the Base Sum Insured granted by the Insurer without an associated increase in premium.

12. **Day Care Centre** means any institution established for Day Care Treatment of illness and / or injuries or a medical set -up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-
   i. has qualified nursing staff under its employment;
   ii. has qualified Medical Practitioner (s) in charge;
   iii. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
   iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

13. **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 hours 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.

14. **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 , which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.

15. **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.

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

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

18. **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.

19. **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 such as 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.

20. **Hospital** means any institution established for In-patient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a Hospital with the local authorities, under 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:
   i. has qualified nursing staff under its employment round the clock;
   ii. has at least 10 In-patient beds, in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;

iii. has qualified Medical Practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

v. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

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

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

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

i) it needs ongoing or long-term monitoring through consultations, examinations, checkups, and /or tests

ii) it needs ongoing or long-term control or relief of symptoms

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

iv) it continues indefinitely

v) it recurs or is likely to recur

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

24. 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.

25. Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

27. Maternity expenses means:

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 advice 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 advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

30. Medically Necessary Treatment means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

i. Is required for the medical management of the Illness or injury suffered by the Insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

iii. must have been prescribed by a Medical Practitioner;

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

31. 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 thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

32. **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.

33. **New Born Baby** means baby born during the Policy Period and is aged up to 90 days.

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

35. **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 diseases and specific waiting periods from one health insurance policy to another with the same insurer.

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

38. **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
    i. that is/are diagnosed by a physician within 36 months prior to the date of commencement of the Policy issued by the insurer; or
    ii. for which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the date of commencement of the Policy.

39. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, provided that:
    i. such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. the In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

40. **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 In-patient 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 diseases 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** 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** means the completed age of the Insured Person as on his/her last birthday.

2. **Ambulance** means a road vehicle operated by a licensed/authorized 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. **Base Sum Insured** means coverage amount for which the premium is computed and charged for this policy.

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 self / legally married spouse/live-in partner/ children/ father/ mother/ father-in-law/ mother-in-law/ son-in-law/ daughter-in-law/ grand-parents/ grandchildren/ uncle/ aunt/ nephew/ niece/ brother/ sister/ sister in-law/ brother in-law.

8. **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 30 years.

9. **Family Floater** means a Policy described as such in the Policy Schedule where under self, legally married spouse or live-in partner, dependent children (natural/legally adopted), dependents parents/ parents-in-law in the Policy Schedule are insured under this Policy as at the Inception Date.

   The Sum Insured for a Family Floater means the sum shown in the Policy Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your dependents during each Policy Period.

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

11. **Indian Resident** means an individual , if he/she is in India for a period amounting in all to one hundred and eighty-two days or more, in the immediately preceding financial year.

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

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

14. **Maternity Sum Insured** means the sum specified in the Policy Schedule against the benefit.

15. **Loss of independent living**

    The Insured Person is permanently unable to perform independently three or more of the following six activities of daily living:

    i. **Washing:** the ability to maintain an adequate level of cleanliness and personal hygiene,

    ii. **Dressing:** the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary,

    iii. **Feeding:** the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available,

    iv. **Toileting:** the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene,

    v. **Mobility:** the ability to move indoors from room to room on level surfaces at the normal place of residence,

    vi. **Transferring:** the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

16. **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.

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

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

19. **Policy Schedule** means schedule attached to and forming part of this Policy mentioning the details of the Policy Holder, Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, Premium Paid (including taxes as applicable), 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.

20. **Single Private AC Room** means a single Hospital room with any rating and of most economical category available at the time of Hospitalization with 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 (unless otherwise specified in the Policy Schedule) 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 available during the Policy Year in respect of that Insured Person (for Individual policy/for Family Floater policy).

    i. In case where the Policy Period is 2/3 years, the Sum Insured is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits of the Sum Insured will be available for the second/third year subsequently.

    ii. In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Year shall stand correspondingly reduced by the amount of claim paid (including 'taxes as applicable') or admitted and shall be reckoned accordingly.

23. **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. **Twin Sharing AC Room** means an air conditioned Hospital room where two patients can be accommodated at same time. Such room shall be the most economical of all accommodations available as twin sharing room in that Hospital.

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

26. **You/Your/Policy Holder** means the person named in the Policy 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. In-patient Hospitalization

We will cover the Medical Expenses of the Insured Person in the event of Medically Necessary Hospitalization arising from an Illness or Injury, provided such Hospitalization is for more than 24 consecutive hours and the date of admission falls within the Policy Year.

We will pay Medical Expenses for the following:

a. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room, up to the category specified in the Policy Schedule,

b. Intensive Care Unit (ICU) accommodation charges,

c. Operation theatre charges,

d. Fees of Medical Practitioner and Surgeon,

e. Anesthetist fees,

f. Qualified nursing charges,

g. Specialists fees,

h. Cost of diagnostic tests,

i. Medicines,

j. Drugs, consumables, blood, oxygen, surgical appliances, and prosthetic devices recommended by the attending Medical Practitioner and used intra operatively during a Surgical Procedure.

Room category coverage under this policy is limited to a Single Private AC Room (unless

otherwise specified in the Policy Schedule), subject to the maximum Sum Insured opted. For ICU accommodation, expenses will be covered up to the Sum Insured opted.

If the Insured Person is admitted to a room category higher than that specified in the Policy Schedule, the Policyholder/Insured Person shall bear a proportionate share of the total Associated Medical Expenses (including surcharge or taxes as applicable). This proportion will be calculated based on the difference between the entitled room rent and the room rent actually incurred.

Under In-patient Hospitalization, when availed as In-patient Care, we will also cover expenses for artificial life maintenance, including the use of life support machine, even when such treatment does not result in recovery or restoration of the insured person's previous state of health, unless the insured person is in a vegetative state, as certified by the treating Medical Practitioner.

The following Modern and Advanced procedures will be covered (wherever medically indicated) either as In-patient or Day Care Treatment in a Hospital, up to the limit specified in the Policy Schedule within a Policy Year.

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

We will cover 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), AIDS Related Complex (ARC), any mutant derivative or variations thereof, and Sexually Transmitted Diseases (STD), up to the Sum Insured specified in the Policy Schedule. Such coverage will be 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 such Hospitalization must be certified by an authorized Medical Practitioner.

We will cover Medical Expenses incurred for the Medically Necessary treatment of the Insured Person for In-patient Hospitalization arising from or associated with Mental illness or medical condition impacting mental health, up to the Sum Insured specified in the Policy Schedule, within a Policy Year. Such coverage will be provided in accordance with The Mental Health Care Act, 2017, as amended from time to time. For the below-mentioned ICD Codes, the Insured Person must have been continuously covered under this Policy for at least 24 months before availing of this benefit.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F10	Alcohol related disorders
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

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

D.I.2 Day Care Treatment

We will cover the Medical Expenses incurred for an Insured Person in the event of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization due to advancement in medical technology. Such treatment must be undertaken in a Hospital, Nursing Home, or Day Care Centre on the recommendation of a Medical Practitioner, up to the Sum Insured as specified in the Policy Schedule, provided that:

a. The Day Care Treatment is Medically Necessary and undertaken based on the written advice of a Medical Practitioner.

b. The Medical Expenses incurred are Reasonable and Customary Charges for the procedure performed as Day Care Treatment.

c. Out-Patient (OPD) Treatment and diagnostic services are not covered under this benefit.

d. Coverage under this benefit shall also include pre-hospitalization and post hospitalization medical expenses, up to the limit specified in the Policy Schedule.

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

D.I.3 Pre-hospitalization Medical Expenses

We will cover, on a reimbursement basis, the Medical Expenses incurred during the Policy Period by the insured person for an Illness or Injury that occurs during the Policy Year, immediately prior to the Insured Person's date of Hospitalization, up to the limit specified in the Policy Schedule. This benefit is payable only if a claim has been admitted as 'In-patient Hospitalization' under section D.I.1 or 'Day Care Treatment' under section D.I.2, and such expenses are related to the same illness or condition.

All claims under this benefit can be made as per the process defined under sections G.I.5 and G.I.9.

D.I.4 Post-hospitalization Medical Expenses

We will cover, on a reimbursement basis, the Medical Expenses incurred by the Insured Person for an Illness or Injury that occurs during the Policy Year, immediately following the Insured Person's discharge from the Hospital, up to the limit specified in the Policy Schedule. This benefit is payable only if a claim has been admitted as 'In-patient Hospitalization' under section D.I.1 or as 'Day Care Treatment' under section D.I.2 and such expenses are related to the same illness/condition.

All claims under this benefit can be made as per the process defined under section G.I.5 and G.I.9.

D.I.5 Domiciliary Hospitalization

We will cover the Medical Expenses of an Insured Person, up to the limits specified in the Policy Schedule, for an Illness or Injury that would normally require Hospitalization but it is instead treated at home on the advice of the attending Medical Practitioner, under the following circumstances:

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

ii. A Hospital bed is unavailable.

Provided that the treatment continues for a minimum period of 3 consecutive days, the reasonable and customary charges of any Medically Necessary treatment for the entire period shall be payable.

a) We will also pay Pre-hospitalization Medical Expenses if incurred during the Policy Period and Post-hospitalization Medical Expenses for up to 30 days each.

b) The Restoration benefit shall not apply under this benefit.

c) We shall not be liable under this Policy for any Claim in connection with or in respect of the following:

i. asthma, COPD, bronchitis, tonsillitis and upper and lower respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,

ii. arthritis, gout and rheumatism including the rheumatism of bones, joints and also rheumatic heart disease,

iii. chronic nephritis and nephritic syndrome,

iv. all types of Diarrhea and dysenteries, including gastroenteritis,

v. diabetes mellitus and Diabetes Insipidus,

vi. epilepsy / Seizure disorder,

vii. hypertension,

viii. pyrexia of unknown origin.

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

D.I.6 Road Ambulance

We will reimburse the Reasonable and Customary expenses, up to the Sum Insured specified in the Policy Schedule, incurred for the road transportation of an Insured Person by a registered Healthcare or Ambulance Service Provider to a nearest Hospital for the treatment of an Illness or Injury covered under this Policy, in case of an Emergency necessitating admission to the nearest Hospital. The necessity of using an Ambulance must be certified by the treating Medical Practitioner.

a. Reasonable and Customary expenses under this benefit shall include:

i. The costs of transferring the Insured Person from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment facility not available at the existing Hospital; or

ii. The cost of transferring the Insured Person to another hospital with better facilities due to lack of super specialty treatment in the existing Hospital.

b. Payment under this benefit shall be subject to a claim being admissible under section D.I.1 'In-patient Hospitalization', for the same Illness/ Injury.

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

D.I.7 Donor Expenses

We will cover the In-patient Hospitalization Medical Expenses incurred for the donor towards organ harvesting, up to the Sum Insured specified in the Policy Schedule, subject to the following conditions:

a. The organ donor must be any person in accordance with the provisions of the Transplantation of Human Organs Act, 1994 (amended), and other applicable laws and rules, provided that the organ is donated for the use of the Insured Person who has been medically advised to undergo an organ transplant.

b. A claim must be admitted under section D.I.1 'In-patient Hospitalization' for the Insured Person

c. We will also cover Medical Expenses incurred for the donor in respect of the following

i. Pre-hospitalization Medical Expenses if incurred during Policy Period or Post-hospitalization Medical Expenses, up to 30 days each.

ii. The Cost of donor screening for organ transplant surgery, provided the organ transplant surgery is successful.

iii. This benefit shall be payable once in a Policy Year.

iv. Complication arising in the Donor, consequent to organ harvesting, during hospitalisation or within 30 days from the date of discharge of the donor, up to the limit specified in the Policy Schedule. This benefit shall be payable in addition to the Base Sum Insured.

We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the donor.

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

D.I.8 AYUSH Treatment

We will cover the Medical Expenses incurred during the Policy Year, up to the Sum Insured specified in the Policy Schedule, for an Insured Person in the event of Medically Necessary Treatment taken for AYUSH Treatment, for an Illness or Injury occurring during the Policy Year, provided such treatment is undertaken in an AYUSH Hospital or AYUSH Day Care Center.

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

i. Expenses incurred on facilities and services availed for purpose of pleasure, rejuvenation, or as a preventive aid, including but not limited to beauty treatments, Panchakarma, purification, detoxification and rejuvenation therapies.

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

D.II Value added covers

D.II.1 Tele-Consultation

An Insured Person may avail unlimited tele-consultations with our network General Physician in India during the Policy Year. For the purpose of this benefit, tele-consultation shall mean a consultation provided by a Medical Practitioner through various communication mode, including but not limited to telephone, videocall or online chat.

All claims under this benefit can be made as per the process defined under section G.I.12.

D.II.2 Wellness Program

You can earn reward points by participating in Our Healthy Life Management Program. By completing the required number of steps per day, as specified in the table below, you can improve your overall well-being while also earning reward points.

Healthy Life Management Program - Rewards Structure				
No. of days	**No. of steps**			
	10,000 steps and above per day	8,000-9,999 steps per day	6,000-7,999 steps per day	Less than 6,000 steps per day
240 days and above	20%	15%	10%	Nil
180 - 239 days	15%	10%	5%	Nil

120 - 179 days	10%	5%	Nil	Nil

Conditions under this benefit:

i. The number of days specified in the table above must fall within the first nine (9) months of each Policy Year. Activities undertaken during the last three (3) months of the Policy Year will not be considered for reward calculation.

ii. In an individual policy, this wellness program is available only for Insured Person(s) of age 18 years or above.

iii. In a floater policy, this wellness program is available only to the adult members and not to dependent children.

iv. In an Individual Policy with one or more members, earning of reward points will be at the member level, where each eligible member may earn up to 20% of their respective expiring base premium subject to the applicable terms and conditions. In a floater policy, earning of reward points will be at the policy level, where all eligible members cumulatively may earn a maximum up to 20% of the expiring base premium, subject to the applicable terms and conditions.

v. In a floater policy the above reward percentage will apportioned among the eligible Adult Insured members as per the illustration below.

In a floater policy, the reward percentage would be divided as per the number of eligible Adults covered.

For Example
In a 2A+2C policy, the Healthy Life Management Program shall be applicable for 2A only. Assuming Adult 1 attains a score of 10,000 steps per day for a period of 240 days and Adult 2 attains a score of 6000 steps per day for a period of 240 days.
The reward points shall be calculated as per the below:
Adult 1: 20% / 2 = 10%
Adult 2: 10% / 2 = 5%
Hence, the total earned reward points would be 10% + 5% = 15% of the existing Policy premium

vi. No reward points will be allocated for any count of steps per day for a period of less than 120 days.

vii. The maximum reward points that can be earned in a single Policy Year will be limited to 20% of the premium paid (excluding premium for Optional covers other than 'Deductible' under section D.III.13, 'Voluntary Co-Payment' under section D.III.14 and Twin sharing room option of 'Room Rent Modification' under section D.III.9, 'Extension of Specific Disease Waiting Period' under section D.III.16, riders and taxes as applicable) in the existing Policy. In the case of 2 or 3 year policies, the maximum reward points that can be earned shall not exceed 20% of the total premium paid (excluding premium for Optional covers other than 'Deductible' under section D.III.13, 'Voluntary Co-Payment' under section D.III.14 and Twin sharing room option of 'Room Rent Modification' under section D.III.9, 'Extension of Specific Disease Waiting Period' under Section D.III.16, riders and taxes as applicable) for 2 years or 3 years as applicable.

viii. Each earned reward point will be valued at ₹1 (One Rupee). Accrued rewards may be redeemed against the payable renewal premium (excluding premium for Optional covers, Riders and Taxes as applicable) from the 1st Renewal of the Policy.

ix. Earned reward points may be utilized only as a discount against the renewal premium due immediately after accrual. Carry forward of unused reward points shall not be allowed.

x. Redemption of reward points against renewal premium shall be available only at the time such renewal is due. Any earned rewards points not utilized 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 Reward Points.

Annexure - A - Illustration of Healthy Life Management Program Rewards

Policy Term - 3 years
(Premium indicated here is just for illustration purposes in case of 1 Adult policy and may not be the actual premium.)
Each earned reward point will be valued at 1 Rupee

Reduction of Renewal Policy Year

Year	Premium (Excluding optional covers/ Rider and taxes as applicable)	Activity	No. of Days	Reward %	Reward Points Earned
Year 1	10000	10,000 and above steps/day	240 days and above	20%	2000
Year 2	11000	8,000 - 9,999 steps/day	240 days and above	15%	1650
Year 3	12000	6,000 - 7,999 steps/ day	240 days and above	10%	1200
Total	33000				4850

The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium

Renewal of Policy as per below table

If Renewed Policy Term is	Renewal Premium (Excluding optional covers, Rider and taxes as applicable)	Reward discount utilized	Renewal Premium Payable after adjusting Reward discount
1 Year Policy	13000	1617 (4850*1/3 as Insured is renewing 3 Year policy to 1 Year Policy)	11383
2 Years Policy	27000	3233 (4850*2/3 as Insured renewing 3 Year policy to 2 Year Policy)	23767
3 Years Policy	42000	4850 (Insured renewing to the same policy tenure of 3 years)	37150

Increase of Renewal Policy Year

Policy Term - 1 year
(Premium indicated here is just for illustration purposes and may not be the actual premium.)
Each earned reward point will be valued at 1 Rupee

Year	Premium paid (Excluding optional cover, Rider and taxes as applicable)	Activity	No. of Days	Reward %	Reward Points Earned
Year 1	10000	6,000 - 7,999 steps / day	180 - 239 days	5%	500
Total	10000				500

The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium

Renewal of Policy as per below table

If Renewed Policy Term is	Renewal Premium (Excluding optional cover, Rider and taxes as applicable)	Rewards discount utilized	Renewal Premium Payable after adjusting Rewards discount
1 Year Policy	11000	500 (as Insured is renewing 1 Year policy to 1 Year Policy)	10500
2 Years Policy	21000	500 (as Insured is renewing 1 Year policy to 2 Year Policy)	20500
3 Years Policy	33000	500 (as Insured is renewing 1 Year policy to 3 Year Policy)	32500

Notifications related to the wellness program shall be communicated to the Policyholder via SMS, email and the program-specific mobile phone/ web application. Details of accrued reward points will be made available through the Mobile App (if any) or shall be communicated via SMS and/or reflected in the Renewal Notice issued to the customers.

D.II.3 Discount from Network Providers

The Insured Person shall be entitled to avail discounts on diagnostics, pharmacy and health supplements when availed through our Network Providers.

D.III. Optional covers

The following optional covers shall be available under the policy, if specifically opted and mentioned in the policy schedule. These covers shall apply uniformly to all Insured Persons under a single policy level, without any individual selection, except for the following benefits which may be opted individually at member level.

- Personal Accident Cover' under section D.III.1,
- 'Temporary Total Disablement' under section D.III.2,and
- Maternity & New Born Hospitalization Expenses' under section D.III.7.

D.III.1 Personal Accident Cover

If an Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in death or disablement of the insured person within 365 days from the date of Accident, We shall pay maximum upto the applicable benefit amount as specified in the policy schedule to

- The Insured Person, or the Nominee, as applicable in case of Death

D.III.1.A Accidental Death (AD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and Injury results in the death of the Insured Person within 365 days from the date of the Accident, We will pay:

- 100% of the opted benefit amount as specified in the Policy Schedule; Or
- 200% of the opted benefit amount if such death occurs while the Insured Person was a fare-paying passenger on a common carrier.

Upon payment of a claim under this benefit, the cover shall automatically terminate for that Insured Person.

D.III.1.B. Permanent Total Disablement (PTD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in Permanent Total Disablement as defined in the table below, within 365 days from the date of the Accident, We will pay:

- 100% of the opted benefit amount as specified in the Policy Schedule; Or
- 200% of the opted benefit amount if such Permanent Total Disablement occurs while the Insured Person was a fare-paying passenger on a common carrier.

Type of Permanent Total Disablement
i. Total and irrecoverable loss of sight of both eye
ii. Loss by physical separation or total and permanent loss of use of both hands or both feet
iii. Loss by physical separation or total and permanent loss of use of one hand and one foot
iv. Total and irrecoverable loss of sight of one eye and loss of a Limb
v. Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
vi. Total and irrecoverable loss of hearing of both ears and loss of speech
vii. Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye
viii. Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment, occupation, or business for remuneration or profit, resulting in "Loss of Independent Living" (Refer Section C.II.15)

For the purpose of this benefit:

- **"Limb"** means a hand at or above the wrist or a foot above the ankle.
- **"Physical separation of one hand or foot"** means separation at or above wrist and/or at or above ankle, respectively.

The benefits specified above will be payable provided that:

a. The Permanent Total Disablement is proven to Our satisfaction; and a disability certificate issued by a Civil Surgeon or the equivalent appointed by the District/State or Government Board; and

b. The Permanent Total Disablement continues for a period of at least 180 days from the commencement, and We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.

c. If the Insured Person dies before a claim has been admitted under this benefit, no amount

will be payable under this benefit. However, a claim may be payable under 'Accidental Death' (Section D.III.1. A), provided coverage under that section applies and intimation of death has been given to Us.

d. If We have admitted a claim for Permanent Total Disablement under this benefit, We shall not be liable to make any further payment under thise benefit Policy in the event of the subsequent death of the Insured Person.

e. Once a claim has been accepted and paid under this benefit, cover under this benefit shall immediately and automatically cease for that Insured Person.

D.III.1.C. Permanent Partial Disablement (PPD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in Permanent Partial Disablement as defined in the table below, within 365 days from the date of the Accident, We will pay the corresponding percentage of the opted benefit amount as specified in the table below:

Table of Benefits	**Percentage of Benefit Amount payable**
i. Total and irrecoverable loss of sight of one eye	50%
ii. Loss of one hand or one foot	50%
iii. Loss of all toes - any one foot	10%
iv. Loss of toe great - any one foot	5%
v. Loss of toes other than great, if more than one toe lost, each	2%
vi. Total and irrecoverable loss of hearing in both ears	50%
vii. Total and irrecoverable loss of hearing in one ear	15%
viii. Total and irrecoverable loss of speech	50%
xi. Loss of four fingers and thumb of one hand	40%
x. Loss of four fingers	35%
xi. Loss of thumb-both phalanges	25%
xii. Loss of thumb - one phalanx	10%
xiii. Loss of index finger - three phalanges - two phalanges - one phalanx	10%, 8%, 4%
xiv. Loss of middle/ring/little finger - three phalanges - two phalanges - one phalanx	6%, 4%, 2%

The benefits specified above will be payable provided that:

a. The Permanent Partial Disablement is proven to Our satisfaction; and is supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by the District/ State or Government Board; and

b. The Permanent Partial Disablement continues for a minimum period of 180 days from its commencement, and We are satisfied at the end of such period that there is no reasonable medical hope of improvement.

c. If the Insured Person dies before a claim has been admitted under this benefit, no amount will be payable under this benefit; However, a claim may be payable under 'Accidental Death' under D.III.1.A, provided coverage under that section applies and intimation of death has been given to Us.

d. In case the Insured Person suffers a loss not specifically mentioned in the Permanent Partial Disablement Table, Our medical advisors will determine the degree of disablement and the payable amount, if any.

e. We will not make any payment under Permanent Partial Disability if We have already paid or accepted any claims under 'Permanent Total Disability' under section D.III.1.B or 'Permanent Partial Disability' under section D.III.1.C in respect of the Insured Person, where the cumulative total amount paid or payable equals or exceeds the opted benefit amount for that Insured Person.

f. Once a claim has been accepted and paid under this benefit, cover under this Policy shall be reduced by the amount paid towards Permanent Partial Disablement for that Insured Person.

Notes:

i. Selection of this cover will be available at member level on individual basis.

ii. Claims under Accidental Death, Permanent Total Disablement, and Permanent Partial Disablement shall be payable only in respect of accident occurring within India

iii. If the Policy Schedule states that non-earning spouse and/or dependent children or dependent parents or dependent parent-in-law of the Proposer are covered under this Optional Cover, then their coverage amount shall be as follows:

a) For non-earning spouse/live-in partner: 60% of the coverage amount chosen for the Proposer.

b) For per dependent child/dependent parents/ dependent parent-in-law: 30% of the coverage amount chosen for the Proposer, subject to maximum of ₹30 Lacs.

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

D.III.2 Temporary Total Disablement (TTD)

If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and such injury solely and directly results in the Temporary Total Disablement of the Insured Person immediately after the Accident, We will pay a fixed benefit amount as specified in the Policy Schedule of this policy per week. This benefit will be payable for the duration of the Temporary Total Disablement.

For the purpose of this benefit, Temporary Total Disablement means a disablement of an Insured Person that renders him or her totally incapable, on a temporary basis, of engaging in any employment, occupation, or business for remuneration or profit, or unable to perform his or her duties of any description whatsoever. Such disablement must be certified by the treating Doctor, Civil Surgeon, or an equivalent authority appointed by the District/State or Government Board.

Note:

i. The TTD benefit can only be opted if the 'Personal Accident Cover' (Section D.III.1) is opted.
ii. The TTD benefit is available only for the earning member in India and shall apply solely to event or occurrence taking place within India.
iii. We shall not be liable to make payments under this benefit for more than a total of 100 weeks in respect of any one Injury, calculated from the date of commencement of the Temporary Total Disablement.
iv. If the Insured Person is disabled for part of the week, then only a proportionate part of the weekly benefit will be payable.

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

D.III.3 Health Check Up

We will provide a comprehensive Health Check-Up to all Insured Persons covered as adults under this policy (excluding dependent children in floater policy), as per eligibility table specified below. Health Check-Ups will be made available irrespective of claim status under the Policy and shall be arranged by Us through our Network Providers.

In the case of an individual policy covering more than one member, upon each member attaining 18 years of age, they become eligible for a health check-up with our Network Provider.

Health Check Up				
Package	Base Sum Insured	Age group	List of tests - Cashless	
			Compulsory Tests	Optional Tests (Any one)
1	₹ 5 Lacs	Up to 40 Years	CBC-ESR, FBS, Lipid Profile, Sr. Creatinine	B1 - Heart monitoring - ECG or B2 - Liver screening - SGOT and SGPT
		Above 40 years	CBC-ESR, FBS, Lipid Profile, Sr. Creatinine	B1 - Heart monitoring - ECG or B2 - Liver screening - SGOT and SGPT or B3 - Thyroid Screening - Thyroid profile or B4 - Diabetes screening - HbA1c
2	₹ 7.5 Lacs, ₹ 10 Lacs,	Up to 40 Years	ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, USG - Abdomen & pelvis	
		Above 40 years	ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, HbA1c, USG Abdomen & Pelvis, PSA (for Males), Mammogram/ PAP Smear (for females)	
3	>₹ 10 Lacs	Upto 40 Years	FBS, Kidney Profile, ECG, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, 2D-Echo, USG Abdomen & Pelvis, Vitamin D3, Vitamin B12	
		Above 40 years	FBS, ECG, HbA1C, Kidney Profile, CBCESR, Lipid Profile, Liver Profile, Thyroid Profile, 2D-Echo, PSA (for Males)/ Mammogram/ PAP Smear (for females), USG Abdomen & Pelvis, Vitamin D3, Vitamin B12,	

Full explanation of Tests is provided here: FBS - Fasting Blood Sugar, ECG - Electrocardiogram, CBC-ESR - Complete Blood Count-Erythrocyte Sedimentation Rate, Sr. Creatinine-Serum Creatinine, HbA1c - Glycosylated Hemoglobin, SGOT - Serum Glutamate oxaloacetate transaminase, SGPT - Serum Glutamate Pyruvate Transaminase, GGT - Gamma Glutamyl Transferase, TMT-Tread Mill Test, PSA - Prostate Specific Antigen, USG -Ultrasound Sonography, TSH- Thyroid Stimulating Hormone, CBC - Complete Blood Count.

Note:

i. This benefit is available once in a Policy Year, including the first Policy Year.

ii. All the tests must be conducted on the same date.

iii. Original copies of all reports will be provided to You.

iv. We shall cover health check-up on a cashless basis only.

v. This benefit will not be available during the free look period of the Policy.

All claims under this benefit can be made as per the process defined under section G.I.12.

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D.III.4 Air Ambulance

We will reimburse the Reasonable and Customary expenses incurred for transporting an Insured Person to the nearest Hospital, or for transfer between healthcare facilities within India, by an Air Ambulance, subject to the following conditions that:

i. The Air Ambulance is used in an Emergency i.e. a life threatening health condition of the Insured Person, requiring immediate and rapid transportation to a Hospital or a medical centre, where ground transport is inadequate;

ii. The Illness/ Injury causing the Emergency is covered under Section D.I.1 'In-patient

Hospitalization';

iii. The transportation is provided by a medically equipped aircraft capable of in-flight medical care, including but not limited to ventilators, ECG monitors, CPR equipment, stretchers, and other monitoring/treatment devices;

iv. Restoration shall not apply to this benefit.

v. The Air Ambulance service is provided by a Registered Ambulance service provider;

vi. The treating Medical Practitioner certifies in writing that the Insured Person's Illness/Injury necessitates Air Ambulance transportation;

vii. Payment under this cover is admissible only if a claim is payable under Section D.I.1 'In-patient Hospitalization' ', for the same Illness/Injury.

The benefit is payable up to the limits specified in the Policy Schedule, subject to a maximum of ₹10 Lacs in a Policy Year, and is payable in addition to the Base Sum Insured.

What is not covered: Expenses incurred for return transportation of the Insured Person's to their home by air ambulance are not covered

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

D.III.5 Restoration

We will provide 100% restoration of the Base Sum Insured any number of times in a Policy Year, whether for the same or unrelated illness/condition and Injury, subject to the following:

i. Restoration shall trigger only if the Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak, if opted and earned), is insufficient due to previous claims in the same Policy Year.

ii. The Restored Sum Insured will apply only to future claims payable under Section D of the Policy and will not apply to the first claim in the Policy Year. Restoration shall be available only for:
   - Section D.I.1 'In-patient Hospitalization'
   - Section D.I.2 'Day Care Treatment'
   - Section D.I.3 'Pre-Hospitalization Medical Expenses'
   - Section D.I.4 'Post-Hospitalization Medical Expenses'
   - Section D.I.6 'Road Ambulance'
   - Section D.I.7 'Donor Expenses'
   - Section D.I.8 'AYUSH Treatment'
   - Section D.III.15 'Coverage for Non-Medical Items and Durable Medical Equipment' (if opted).

iii. The Restored Sum Insured will not be considered for calculation of the Guaranteed Cumulative Bonus (Gullak, if opted).

iv. Restoration will be available any number of times in a Policy Year for each Insured Person under an Individual Policy and may be utilized by Insured Persons covered before the exhaustion of the Base Sum Insured.

v. Under a Floater Policy, the Restored Sum Insured shall also apply on a floater basis.

vi. Any unutilized Restored Sum Insured will not be carried forward to subsequent Policy Years.

vii. For any single claim in a Policy Year, the maximum claim payable shall be the sum of
   a) Base Sum Insured
   b) Guaranteed Cumulative Bonus (Gullak if opted and earned)
   c) Surplus Benefit (Applicable for 1st Claim (if opted)/Shakti (if opted))
   d) Restoration (if opted)

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

D.III.6 Gullak (Guaranteed Cumulative Bonus)

We will increase Your Base Sum Insured by 100% of the amount specified (Base Sum Insured) in the Policy Schedule at the end of the Policy Year and shall be available from the subsequent Policy Year, provided the Policy is renewed with Us without any break.

Note:

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

ii. The Guaranteed Cumulative Bonus (Gullak) shall not exceed 1500% of the Base Sum Insured under the Current Policy under any circumstances.

iii. Any Guaranteed Cumulative Bonus (Gullak) accrued for a Policy Year will be credited at the end of that Policy Year if the Policy is renewed with Us within the Grace period. It will be available for claims made in the subsequent Policy Year.

iv. Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and are renewed on a Family Floater basis, the Guaranteed Cumulative Bonus (Gullak) carried forward to the renewed policy shall be the lowest percentage applicable to the lowest Base Sum Insured amongst all expiring polices merged.

v. Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and renew by splitting the Base Sum Insured into two or more Family Floater/Individual policies, the Guaranteed Cumulative Bonus (Gullak) shall be apportioned proportionately to the Base Sum Insured of each Renewed Policy.

vi. Reduction in Base Sum Insured: If the Base Sum

Insured is reduced at Renewal, the applicable Guaranteed Cumulative Bonus (Gullak) will be calculated on the revised Base Sum Insured on a pro-rata basis.

vii. Increase in Base Sum Insured: If the Base Sum Insured is increased at Renewal, the Guaranteed Cumulative Bonus (Gullak) will be calculated on the Base Sum Insured of the last completed Policy Year.

viii. If You opt out of this Optional Cover at the time of Policy renewal, the accumulated Guaranteed Cumulative Bonus (Gullak) under the expiring Policy shall be forfeited.

ix. This Guaranteed Cumulative Bonus (Gullak) shall not be available for claims made for Value Added Covers (Section D.II), for coverage under section D.III.1 'Personal Accident Cover' if opted, coverage under section D.III.2 Total Temporary Disablement (TTD) if opted, coverage under section D.III.7 'Maternity & New Born Hospitalization Expenses' if opted and coverage under section D.III.4 'Air Ambulance Cover' if opted.

All claims under this benefit can be made as per the process defined under section G.I.4 & G.I.5 of Policy.

D.III.7 Maternity & New Born Hospitalization Expenses

D.III.7.A. Maternity Expenses

We will cover Maternity Expenses up to the Maternity Sum Insured as specified in the Policy 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, subject to a maximum of 2 deliveries or terminations during the lifetime of an Insured Person with Us.

You understand and agree that:

i. Our maximum liability per delivery or termination shall be restricted to the Maternity Sum Insured specified in the Policy Schedule.

ii. The female adult Insured Person should have been continuously covered under the Policy for at least 36 months before availing this benefit.

iii. In case the Policy is migrated (i.e. transferred from another health product/plan offered by Us), the Insured Person shall be entitled to continuity of the waiting period only up to the Maternity Sum Insured available under the previous policy. Any increase in the Maternity Sum Insured under this Policy shall be subject to a fresh waiting period applicable on the enhanced portion.

iv. Payment towards any admissible claim under this benefit for any complication arising out of or as a consequence of maternity or childbirth will be restricted to the Maternity Sum Insured specified in the Policy Schedule.

v. The Restoration will not be available under this section.

vi. Pre or post-natal Maternity Expenses will be covered within the Maternity Sum Insured under this benefit.

vii. The Maternity Sum Insured shall be available in addition to the base Sum Insured.

viii. Any Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.

ix. The following expenses will not be covered under the Maternity Benefit:

a. Medical Expenses in respect of harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.

b. Medical Expenses for ectopic pregnancy, however,these will be covered under the 'In-patient Hospitalization' of base cover under section D.I.1.

x. Exclusion E.I.18 (maternity related exclusion) shall not apply to the extent of coverage provided through this optional cover, subject to the terms and conditions of this benefit.

xi. For the purpose this benefit, the birth of twin children or more under a single delivery shall be considered a single event.

xii. In Individual/Multi-Individual policies, Maternity Expenses can also be opted for/by any female who has attained the age of 18 years. Maternity Expenses can also be opted by an Adult Male Insured Person, however, any claim under this benefit shall be payable only to the female spouse of such adult male Insured Person upon adding her as an Insured Person under the Policy. In such cases, the applicable waiting period shall be as per the first inception of this optional cover and its continuity.

xiii. In Floater Policies, the Maternity Expenses optional cover will be available only for Self(female), Spouse and Live-In partner.

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

D.III.7.B New Born Baby Expenses

Subject to a claim being paid under the Maternity Cover under Section D.III.7.A, We will cover:

i. Medical Expenses for the treatment of the New Born Baby while the Insured Person is hospitalized as an In-patient for delivery.

ii. 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 Policy Schedule under Maternity Expenses, without payment of any additional premium.

iii. Restoration will not be available for coverage under this section.

iv. Subject to underwriting and the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days upon payment of the requisite premium for adding the New Born Baby into the Policy, either by way of an endorsement or at the next Renewal, whichever is earlier.

v. Any Voluntary Co-Payment or Deductible (if opted) 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.III.7.C First Year Vaccinations

We will cover the Reasonable and Customary charges for vaccination expenses for the New Born Baby as per the National Immunization Scheme (India) listed below, until the child completes 12 months of age, within the limits specified in the Policy Schedule under Maternity Expenses without payment of any additional premium. If the Policy terminates before the New Born Baby completes 12 months of age, coverage under this benefit shall continue, subject to renewal of the policy in the subsequent policy year. Restoration shall not be available for coverage under this section.

Time Interval	Vaccinations to be done (Age)	Fre-quency
0 - 3 months	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

Note: Our maximum cumulative liability under Section D.III.7 shall be restricted to the 'Maternity & New Born Hospitalization Expenses' Sum Insured specified in the Policy Schedule for any and all claims incurred under Maternity Expenses (D.III.7.A), New Born Expenses (D.III.7.B) and First Year Vaccinations (D.III.7.C). Maximum amount of claim payout shall be based on the available Sum Insured of a given Policy Year basis the date of delivery.

All claims under this benefit can be made as per the process defined under section G.I.5 of Policy.

D.III.8 Sarathi

If the Policyholder has opted for this Optional Cover, any condition, illness, complication or ailment arising out of the below mentioned pre-existing diseases, declared and accepted by Us, shall not be subject to the standard Pre-Existing Disease waiting period [Exclusion E.I.1]. Such conditions will be covered after a 30 day waiting period from the Inception Date of the first policy with Us.

i. Asthma
ii. Diabetes
iii. Dyslipidemia
iv. Obesity
v. Hypertension

Note – This optional cover can be availed only at the time of purchase of the first Policy and shall not be available at renewal. Once opted, this cover shall continue in subsequent renewals and cannot be opted out.

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

D.III.9 Room Rent Modification

We offer the option to modify the room category limit to either "Any Room" or "Twin Sharing AC room" as per the Policyholder's choice and the same shall be specified in the Policy Schedule. This coverage shall be available up to the Sum Insured specified in the Policy schedule.

For ICU accommodation, coverage will continue to be provided up to the Sum Insured.

D.III.10 Surplus Benefit

We offer an option to avail an additional amount equal to the opted Base Sum Insured, as specified in the Policy Schedule, for the first claim in every Policy Year, subject to the following:

i. The Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak if opted and earned), is insufficient for the first claim in that Policy Year.
ii. The Surplus Benefit will not be considered while calculating Guaranteed Cumulative Bonus (Gullak if opted and earned).
iii. If the Policy is issued on a floater basis, the Surplus Benefit will also be available on floater basis.
iv. Any unutilized Surplus Benefit after the first claim of a Policy Year shall not be carried forward to subsequent claims in the same Policy Year or to the next Policy Year.
v. The Surplus Benefit and Shakti (Section D.III.11) are mutually exclusive, only one may be opted for under the policy

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

D.III.11 Shakti

We offer an option to avail an additional amount of 100% or 200% of Base Sum Insured, as specified in the Policy Schedule, for all claims in a Policy Year, subject to the following conditions:

i. The Sum Insured, inclusive of the Guaranteed Cumulative Bonus (Gullak, if opted and earned), is insufficient to pay claim.
ii. The benefit amount shall not be considered while calculating the Guaranteed Cumulative Bonus (Gullak if opted and earned).
iii. If the Policy is issued on a floater basis, thebenefit amount will also be available on floater basis.
iv. Any unutilized benefit amount of any Policy Year shall not be carried forward to the subsequent Policy Year.
v. The balance benefit amount may be utilized for any number of admissible claims during the Policy Year.
vi. The Surplus Benefit (Section D.III.10) and Shakti benefit are mutually exclusive; only one may be opted for under the Policy.

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

D.III.12 Anant

If the Policyholder opts for this Optional Cover, in the event of any Hospitalization related to Cancer, Heart, Stroke, Major Organ / Bone Marrow Transplant or Accident, We will cover all Medical Expenses incurred under:

- Section D.I.1 “In-patient Hospitalisation”,
- Section D.I.2 “Day Care Treatment”, and
- Section D.I.8 “AYUSH Treatment”,

without any Sum Insured limit for any number of times in a Policy Year.

Notes:

i. This optional cover can be opted only at the first policy purchase with Us and cannot be opted at subsequent renewal. .
ii. Available for Base Sum Insured of ₹10 Lacs and above.
iii. This benefit will apply at the Policy level, irrespective of Policy type.
iv. Voluntary Co-payment and Deductible (if opted) shall also apply to this benefit.
v. Sequence of utilization of benefits will be as follows:
   a. Base Sum Insured
   b. Guaranteed Cumulative Bonus (Gullak, if opted and earned)
   c. Surplus Benefit / Shakti (if opted)
   d. Restoration (if opted and applicable)
   e. Anant (towards balance claim amount)
vi. This benefit applies only to events diagnosed, or occurrences taking place, and treatment taken in India.

Definition for the Purpose of this Cover:

For the purpose of this benefit:

- **Cancer –** Cancer is defined as a malignant tumor characterized by the uncontrolled growth & spread of malignant cells, leading to the invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma but excludes benign or non-malignant tumors.
- **Heart**
  - **Coronary Artery Disease (CAD)** is a condition characterized by the narrowing or blockage of the coronary arteries due to the buildup of atherosclerotic plaques, leading to a reduction in blood flow to the heart muscle.
  - **Heart Arrhythmias** are conditions characterized by an irregular heartbeat, this irregularity can manifest as a heartbeat that is too fast (tachycardia), too slow(bradycardia), or erratic.
  - **Valvular Heart Disease** is a condition characterized by any dysfunction or abnormality of one or more of the heart's four valves: the aortic, mitral, pulmonary, and tricuspid valves.
  - **Rheumatic Heart Disease** is a chronic inflammatory condition leading to permanent damage to the heart valves, resulting from rheumatic fever.
  - **Heart Failure (HF)** also known as congestive heart failure, is a chronic and progressive condition caused by impairment in the heart's ability to fill with and pump blood to meet the body's needs for blood and oxygen.
  - **Pericardial Disease** refers to a group of conditions affecting the pericardium, the double layered sac surrounding the heart leading to inflammation, fluid accumulation, or structural changes in the pericardium, impacting the heart's function.
  - **Cardiomyopathy (Heart Muscle Disease)** is a group of diseases that affects myocardium (heart muscle), leading to impaired cardiac functions (contractions & relaxations)

Exclusions:

- Heart diseases caused by illicit drug use, substance abuse, Alcohol or non-prescribed medications.
- Self-inflicted injuries or conditions resulting from non-compliance with medical advice.
- Congenital heart diseases
- Hospitalization for Hypertension and associated illness unless impacting the Heart & resulting in any condition covered under plan.

- **Stroke** is a medical emergency characterized by the sudden interruption of blood supply to the brain, leading to brain cell death and potential long-term neurological damage.
- **Major Organ / Bone Marrow Transplant** refers to heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ.A major organ/bone marrow transplant is a complex medical procedure where a diseased or damaged organ or bone marrow with irreversible end-stage failure is replaced with a healthy one from a donor.
- **Accident** – A sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

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

D.III.13 Deductible

You can opt for a Deductible and the same shall be specified in the Policy Schedule. There are 2 types of Deductible options available:

a. Aggregate Deductible - The deductible amount will be applied for each Policy Year on the aggregate of all admissible claims in that Policy Year.

b. Daily Deductible-The deductible amount will be applied per day of Hospitalization on all admissible claims.

Note:

i. The Deductible can be opted-in or opted out at Inception or at Renewal of the Policy.

ii. Opting out of the Deductible may be subject to underwriting. Once opted-out cannot be opted in again at subsequent renewals.

iii. For Aggregate deductible amount other than ₹10,000 or ₹25,000, if the insured opt out of the Deductible at any renewal, a fresh waiting period shall apply for the initial enhanced limit from the effective date of such enhancement.

iv. Any Voluntary Co-Payment shall not apply to plans with Deductible options.

v. The Deductible opted shall apply on all claims other than those covered under:

- Section D.III.1 'Personal Accident Cover'
- Section D.III.2 'Temporary Total Disablement'
- Section D.III.3 'Health Check-Ups'
- Section D.III.4 'Air Ambulance'
- Section D.II 'Value Added Covers'

For the purpose of applying the deductible and assessing admissibility, all claims must be submitted in accordance with section G.I.4 & G.I.5 of the Claim Process. All other terms, conditions, waiting periods and exclusions of the Policy shall apply.

D.III.14. Voluntary Co-Payment

Irrespective of the Age and number of claims made by the Insured Person, and subject to the Co-payment option chosen by You and specified in the Policy Schedule, We will pay 90% or 80% or 70% of any assessed payable in respect of a claim under the Policy, and the balance will be borne by the Insured Person.

Note:

i. The Voluntary Co-payment can be opted-in or opted-out at Inception or at Renewal of the Policy. However, opting out at Renewal will be subject to underwriting evaluation. Once opted-out cannot be opted in again at subsequent renewals

ii. The Voluntary Co-payment shall apply to all Sections other than:
- Section D.III.1 'Personal Accident Cover'
- Section D.III.2 'Temporary Total Disablement'
- Section D.III.3 'Health Check-Ups'
- Section D.III.4 'Air Ambulance'
- Section D.II 'Value Added Covers'

iii. If opted, the Voluntary Co-payment shall apply in addition to any other Co-payment applicable under this Policy.

D.III.15 Coverage for Non-Medical Items and Durable Medical Equipment

D.III.15.A Non-Medical Items

The cover is available subject to the claim being admissible under

- Section D.I.1 'In-patient Hospitalisation', or
- Section D.I.2 'Day Care Treatment', or
- Section D.I.5 'Domiciliary Hospitalization',

and provided that the expenses on Non-Medical Items are related to the same Illness/Injury.

Note:

i. Exclusion with respect to any of the Non-Medical Items listed in Annexure III List-1 shall not apply under this benefit.

ii. Any claim made under this cover will reduce the available Sum Insured of the Policy.

iii. Exclusion under section E.II.13 shall not apply to this cover, subject to terms and conditions specified herein.

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

D.III.15.B Durable Medical Equipment

We will cover the Reasonable and Customary expenses towards the cost of purchasing or renting Durable Medical Equipment, as listed below, provided the same is prescribed to the Insured Person by the treating Medical Practitioner during or after Hospitalization for medically necessary treatment.

The cover is available subject to below conditions:

i. The Hospitalization claim is admissible under section D.I.1 'In-patient Hospitalization' or under section D.I.2 'Day Care Treatment' or under section D.I.5 'Domiciliary Hospitalization' under the Policy, and the expenses on Durable Medical Equipment must be related to the same Illness/ Injury.

ii. The need for Durable Medical Equipment must be prescribed by an authorised Medical Practitioner during Hospitalization or within 30 days post discharge of the insured from the hospital.

iii. Purchase or rental of the prescribed Durable Medical Equipment must be completed within 30 days of such recommendation.

iv. Exclusion E.II.4 shall not apply to this cover, subject to terms and conditions under this benefit.

For the purpose of this benefit, Durable Medical Equipment shall mean -

Sr. No	List of Durable Medical Equipment
1	CPAP machine
2	BPAP machine
3	Ventilator
4	Wheelchair
5	Prosthetic device
6	Suction Machine
7	Commode Chairs
8	Infusion pump
9	Continuous Passive motion devices in case of Knee Replacement
10	Oxygen concentrator

Note:

i. For this cover, a Prosthetic device means an externally applied device used to replace wholly or partly an absent or deficient body part (limited to arm or leg or auditory system).

ii. Benefit under this cover is payable up to a maximum of ₹1 Lac in a Policy Year.

iii. Any claim made under this cover will reduce the Base Sum Insured of the Policy.

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

D.III.16. Extension of Specific Disease Waiting Period

By opting for this optional cover, the Policyholder agrees to extend the waiting period for Specified Diseases or Procedures (as mentioned under Section E.I.2) to 36 months.

Note:

i. This optional cover can be opted at the first policy purchase with Us and cannot be opted at subsequent renewal.

ii. Once this optional cover is opted, it cannot be opted out in subsequent renewal.

iii. This benefit will be applied at the policy level irrespective of policy type.

iv. Selection of this optional cover is not applicable for Portability/Migration cases.

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

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 periods shall be applicable individually to 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 36 months of continuous coverage after the date of inception of the first Policy with Insurer.

b. In case of enhancement of Base Sum Insured, the exclusion shall apply afresh to the extent of Base 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- Excl. 02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months (36 months in case 'Extension of Specific Disease Waiting Period' is opted) 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 Base sum insured the exclusion shall apply afresh to the extent of Base 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. Endometriosis, Dilatation and curettage, Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus or myomectomy for fibroids unless necessitated by malignancy

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, 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, Removal of Implants and all diseases of Ligament, tendon, meniscal tear (other than caused by accident or malignancy).

iv. Varicose Veins and Varicose Ulcers,

v. Stones in the urinary genito-urinary and biliary systems including calculus diseases and complications thereof,

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 & biliary 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 Policy Schedule shall apply.

E.I.3 30 days Waiting Period - Code- Excl. 03

a. Expenses related to the treatment of any illness within 30 days 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 Base 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

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 Type2 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.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.

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

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

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

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 Personal Waiting period

A special Waiting Period, not exceeding 36 months, may be applied to individual Insured Persons for specific medical Ailments listed under the Underwriting Manual of this Product. The applicability of such a waiting period will depend upon the health declarations made in the Proposal Form and the Insured Person's existing medical condition.Such specific waiting periods shall:

-Be specifically stated in the Policy Schedule, and

-Be applied only after receiving the explicit consent of the Insured Person/Proposer.

E.II.2 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.3 Circumcision unless necessary for treatment of illness or injury not excluded hereunder or due to an accident.

E.II.4. 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.5 External Congenital Anomaly or defects or any complications or conditions arising therefrom.

E.II.6 Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was Hospitalized.

E.II.7 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.8 Treatment received outside the geographical limits of India.

E.II.9 Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body subject to conditions mentioned in D.I.7 'Organ Donor'.

E.II.10 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.11 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, chemical or biological attack or in any other sequence to the loss.

E.II.12 All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the illness/injury for which the Insured Person was 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 III List - I "Items for which Coverage is not available in the Policy" subject to conditions mentioned in D.III.15 'Coverage for Non-Medical Items and Durable Medical Equipment's'.

E.II.13 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.14 Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Policy Schedule.

E.II.15 Any Pre-existing condition disclosed by the Insured Person will be reviewed and assessed in according with the company's underwriting policy.

E.II.16 Expenses incurred towards all types of Multi-focal Lenses, Multi-focal toric lenses and Femto Laser-assisted Surgeries for the treatment of Cataract, subject to Policy terms and conditions.

Note:

a. Femto Laser Surgeries refer to advanced medical procedures utilizing femtosecond laser technology for precision-based treatments, commonly used in ophthalmic surgeries such as LASIK or cataract removal.

b. Multi-focal Lenses include intraocular lenses designed to provide vision correction at multiple distances, such as bifocal, trifocal, progressive lenses, or any other premium intraocular lenses.

E.II.17 Expenses related to any Modern & Advanced Treatments other than those covered under this Policy shall not be payable.

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

E.III.1 Listed Pre-existing Disease (Asthma, Diabetes, Dyslipidemia, Obesity, Hypertension) - Code- Excl. 01

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy with Insurer.

b. In case of enhancement of Base Sum Insured, the exclusion shall apply afresh to the extent of Base 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.

(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.8 of the Policy and limits as specified in the Policy Schedule)

E.III.2 Maternity: Code Excl 18

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.

(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.7 of the Policy and limits as specified in the Policy Schedule)

E.III.3 Instruments 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.

(Benefits covered, upon payment of additional premium under this exclusion, shall be limited to the extent specified under the corresponding section (D.III.15) of the Policy and the limits as specified in the Policy Schedule)

E.III.4 All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the illness/injury for which the Insured Person was 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.

(Benefits covered, upon payment of additional premium under this exclusion, shall be limited to the extent specified under the corresponding section (D.III.15) of the Policy and the 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 misdescription 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

If an Insured Person holds policies from more than one Insurer covering the same risk on an indemnity basis, indemnification for treatment costs shall be provided only in accordance with the terms and conditions of the policy chosen by the Insured.

In the case of multiple indemnity policies held by an Insured Person, they have the right to request settlement of their claim under any one of their policies, provided full disclosure of all existing policies is made to the chosen Insurer at the policy inception or at the time of claim intimation.

Upon claim settlement, the Insurer selected by the Insured shall be considered the Primary Insurer and will be responsible for settling the claim within the limits and terms of the chosen policy. If the available coverage under the chosen policy is insufficient to cover the admissible claim amount, the Primary Insurer shall coordinate with the other Insurer(s) to ensure settlement of the balance amount in accordance with the respective policy contracts

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 made under this Policy which are found fraudulent later shall be repaid by all recipients(s)/Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/ doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance Policy:-

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

ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and

iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the claim and/ or forfeit the policy benefits on the grounds of Fraud, if the Insured Person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

F.I.7 Cancellation

The Policyholder may cancel this policy anytime during the policy term by providing 7 days' written notice. Upon cancellation, the Company shall refund the premium for the unexpired policy period as detailed below:

A. Policy Tenure of 1 Year:

- **No claim made:** 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 the expiry date of coverage.
- **Claim made:** No refund will be given if a claim has been made or any benefit has been availed during the Policy period.

Illustration:

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

Policy Start Date 01-07-2023	01-07-2023
Policy End Date 30-06-2024	30-06-2024
Tenure (in Year)	1
Latest Claim Date NA	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 (in Year)	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:

- No claim in the current policy year:
  i. A proportionate refund of the premium will be issued for the unexpired period upon cancellation.
  ii. The date of cancellation will be considered as the expiry date of coverage.
- Claim made in the current policy year:
  i. Premium for the remaining complete policy year(s) will be refunded on cancellation.
- Claim made in a previous policy year:
  i. A proportionate refund of the premium will be issued for the unexpired period upon cancellation.
  ii. The date of 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 (in Years)	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 (in Years)	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)

C. Company right to cancel:

The company reserve the right to cancel the policy at any time by providing 15 days written notice on ground of misrepresentation, non-disclosure of material facts, or established fraud by the Policyholder/Insured Person. There is no refund of premium in case of cancellation on these grounds.

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 , to the extent of the Base Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period 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 to the extent of the Base Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, moratorium period as per IRDAI guidelines on portability.

F.I.10 Renewal of Policy

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

i. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end

of the Policy Period.

iii. 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.

iv. No loading shall apply on Renewals based on individual claims experience.

F.I.11 Withdrawal of Policy

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

ii. Insured Person will have the option to migrate to similar health insurance products available with the Company at the time of renewal with all the accrued continuity benefits such as Gullak (Guaranteed 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 Base Sum Insured of the first Policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of Base SumInsured 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 Policyholder has opted for Payment of Premium on an Instalment basis i.e. Half-yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, 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 15 days for monthly mode of payment 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 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 Policyholder shall be notified at least 45 days 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.: 022-61703600

Courier: You may send your grievance to any of our branch offices or corporate office during business hours.

You may also approach the grievance cell at any of the Company's branches with the grievance details.

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

The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

401/402, 4th Floor, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai - 400063, Maharashtra, 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. However all admitted or payable claims shall be settled in India in Indian rupees.

F.II.6 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.7 Grace Period

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Illness/Injury/ Accident/ Condition that occurred during the Grace Period[F.I.13 Premium Payment in Instalments].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.8 Renewal Terms

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

ii. 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.

iii. Renewals will not be denied except on grounds of misrepresentation, established fraud, non-disclosure of material facts by You.

iv. 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.

v. 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.

vi. 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 45 days before the changes are effected.

vii. Alterations like increase/ decrease in Base Sum Insured or Change in Plan/Product, addition/ deletion of members, addition/deletion of optional covers/riders, 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 Base Sum Insured on Renewal. The terms and conditions of the existing Policy will not be altered.

viii. Any enhanced Base 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.

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

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

xi. Applicable Guaranteed Cumulative Bonus (Gullak If opted and earned) shall be accrued at the end Policy year as per eligibility under the Policy.

xii. In case of floater policies, children attaining 31 years or more 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. Guaranteed Cumulative Bonus (Gullak if opted and earned) on the Policy will stay with the floater cover.

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

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

ii. The Premium amount which would be auto debited & frequency 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.9 Premium calculation

Premium will be calculated based on the Base Sum Insured opted, Age, risk classification, optional cover selected, family combination and Zone

classification. Zone classification will be based on Proposer's city-location pin code as mentioned in CKYC documents.

For premium calculation of floater policies, Age of eldest member would be considered.Premium can be paid on Single, 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.

Note - Instalment facility shall not be available for the policy tenure more than 1 year. In case of premium payment modes other than Single, 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

Identification of Zone will be based on Proposer's city-location pin code as mentioned in KYC documents.

The residential address provided by You should be true, correct and complete. Any discrepancy or mismatch identified during claim adjudication may lead to delays, disputes or denial of claim settlement. The policyholder is required to promptly inform the company of any changes to the residential address to ensure uninterrupted communication and smooth claim processing.

Zone	Region / District / State
Zone 1	**Delhi & NCR** **Districts in Gujarat:** Ahmedabad, Gandhinagar, Surat, Vadodara **Districts in Maharashtra:** Mumbai, Thane, Navi Mumbai **Districts in Andhra Pradesh/Telangana:** Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal **Districts in Uttar Pradesh:** Mathura, Jyotiba Fule Nagar (Amroha), Aligarh **Others:** Rewari, Jind, Jhunjhunu, Patna
Zone 2	**Rest of the Bihar State** **Districts in Andhra Pradesh/Telangana:** Ananthapur, Bapatla, Gadwal, Guntur, Kamareddy, Kurnool, Mahabubnagar, Medak, Nalgonda, Nellore, Nizamabad, Rangareddy, Suryapet, Wanaparthy **Districts in Punjab:** Amritsar, Gurdaspur **Districts in Maharashtra:** Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad **Others:** Chennai, Bangalore, Kolkata, Dhanbad, Bokaro
Zone 3	**Daman & Diu UT, Dadara & Nagar Haveli UT, Rest of Andhra Pradesh State, Rest of Telangana State, Rest of Gujarat State, Rest of Haryana State** **Districts in Karnataka:** Chikkaballapur, Chikkamagaluru, Kolar, Tumakuru, Udupi **Districts in Punjab:** Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, S.A.S. Nagar (Mohali), Patiala **Districts in Rajasthan:** Dausa, Dholpur, Jaipur, Karauli, Sawai Madhopur, Tonk, **Districts in Tamilnadu:** Coimbatore, Erode, Kanchipuram, Karur, Krishnagiri, Tiruppur, Tiruvallur **Districts in Uttar Pradesh:** Kanpur, Banda, Fatehpur **Others:** Chandigarh, Raipur, Wayanad
Zone 4	**Rest of India**
Note - Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts.	

F.II.10 Discounts under the Policy

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

Lifetime Discounts		
a.	Early Renewal Discount or Standing Instruction Discount	You are eligible for a 2.5% discount on the Renewal premium if the Policy is renewed on or before 15 days of the Policy expiry date. OR You are eligible for a 2.5% discount on the renewal premium, if the renewal premium is received through standing instruction. **Note -** Early Renewal Discount and Standing Instruction Discount are mutually exclusive, only one of these discount can be applied at given point in time.
b.	Long Term Policy Discount	Discount of 7.5% is applicable for selecting a 2-year Policy and 10% for a 3-year Policy. This discount is available only under the Single Premium payment mode.
c.	Family Discount	10% discount on the premium is applicable when covering 2 members under the same individual Policy on Multi-Individual basis.
d.	Direct Discount	5% discount will be offered if the policy is purchased directly from the insurer without any intermediary.

<table>
<tr><td>e.</td><td>Employee Discount</td><td>10% discount on the premium</td></tr>
<tr><td>f.</td><td>No Claim Discount</td><td>The Policy will be eligible for a discount on the Renewal Premium based on the number of previous consecutive claim-free years as per the table below:
<table>
<tr><th>Claim free years</th><th>Discount</th></tr>
<tr><td>1 year</td><td><<2.5%>></td></tr>
<tr><td>2 years</td><td><<5%>></td></tr>
<tr><td>3 years</td><td><<7.5%>></td></tr>
</table>
Note:
i. In case of any claim, the claim-free count will reset and will start afresh from the subsequent Policy Year.
ii. The Calculation of the claim-free discount will not be affected by any utilization of the following benefit:
• Section D.II Value Added Covers, including:
o Tele-consultation (Section D.II.1)
o Wellness (Section D.II.2)
o Discount from Network Provider (Section D.II.3)
o Health Check-up (Section D.II.4)
o Add-Ons / Riders
iii. Progression to higher discount levels (1 Year, 2 Years, 3 Years) will stop once the eldest member covered under the policy attains the age of 56 years.
iv. The attained discount level at the age of 56 will continue until a claim is made under the Policy. After a claim, the discount level will reset to 0 andshall not be accrued in subsequent policy year irrespective of claim history.
Note: No Claim Discount and 1st Renewal Discount are mutually exclusive. Policyholder to receive maximum discount applied out of the 2.</td></tr>
<tr><td colspan="3">Short Term Discounts</td></tr>
<tr><td>a.</td><td>1st Policy Renewal Discount</td><td>5% discount on your first policy renewal premium.</td></tr>
<tr><td>b.</td><td>Worksite Marketing Discount</td><td>Discount of 10% will be applicable for policies sourced through the Worksite Marketing channel. This discount is applicable only once, at the inception of the Policy.</td></tr>
<tr><td>c.</td><td>Discount in lieu of Commis-sion</td><td>Maximum discount up to 15% will be provided on premium once only at inception of the Policy, in case the intermediary forgoes their commission.</td></tr>
<tr><td colspan="3">Note -
ii. Direct Discount, Employee Discount, Worksite Marketing Discount and Discount in lieu of commission are mutually exclusive.
iii. Maximum cumulative discount on a single policy for the above mentioned parameters shall not exceed 40%.</td></tr>
</table>

F.II.11 Loadings & Special Conditions

We may apply a risk loading on the premium payable (excluding Statutory Levies and Taxes as applicable as applicable) 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 additional premium (if any), within the duration specified in the counter offer letter.

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

F.II.12 Communications & Notices

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

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

ii. To Us, at the address specified in the Policy Schedule.

iii. No insurance agents, brokers, other person or entity is authorized to receive any notice on the

behalf of Us unless explicitly stated in writing by Us.

iv. 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.13 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.14 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.15 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.16 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 the premium by their respective due dates) as they relate to anything to be done or complied with You or any Insured Person, including complying with the following steps, may 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 required time shall not invalidate or reduce any claim if You can satisfy Us that it was not reasonably possible for You to submit or give proof within such time.

The due intimation, submission of documents, and compliance with requirements as provided under the Claims Process in 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 may be facilitated 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 on Our website or through Our call center before availing the Cashless services.

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

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

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

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

(d) Assist and not hinder or prevent Our representatives in the pursuit of their duties

for ascertaining the admissibility of the claim, its circumstances, and its quantum under the provisions of the Policy.

(e). Policyholders/Insured Person(s)/any person behalf of You are strictly advised not to share or post any claim-related information, personal details, or medical records on any medium or platform other than those officially specified by the Company in this Policy, as doing so may compromise the confidentiality and security of your personal information and personal health details.

G.I.3 Claim Intimation

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

In the event of any Illness, 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 must intimate such admission at least 48 hours prior to the planned date of admission.
- Emergency Hospitalization- You/the Insured Person must 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 relation to whom 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

The Claim documents specified above may be securely uploaded on either our official mobile application - 'myManipalCigna' or on our website https://claim.manipalcigna.com/claims/ . It can also be submitted in physical form at our designated Claims Office-

Address- Techweb center 2nd Floor New Link Rd, Anand Nagar, Jogeshwari West, Mumbai, Maharashtra 400102, India'

G.I.4 Cashless Facility

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

a) For Planned Hospitalization:

i. The Insured Person should approach the Network Provider for Hospitalization for medical treatment at least 48 hours prior to admission to the Hospital.

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

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

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

v. Wherever the information provided in the request is sufficient to ascertain the authorization, We shall issue the authorization Letter to the Network Provider. Wherever additional information or documents are required, We will call for the same from the Network provider and, upon satisfactory receipt of the necessary documents, the authorization will be issued. All authorizations will be issued within a period of 1 hour from the receipt of request.

vi. The Authorization letter will include details of sanctioned amount, any specific limitation on the claim, any co-pays or deductibles, and Non-Medical expenses (as defined under Annexure III List-1 of the policy), if applicable.

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

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

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

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

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

iv. In the event of a change in the treatment during Hospitalization to the Insured Person,

the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under G.I.4 (a) above.

At the time of discharge:

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

ii. We shall accept or decline such additional expenses within 3 (Three) hours of receipt of request for final discharge from Network provider.

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

b) In case of Emergency Hospitalization

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

ii. The Network Provider shall forward the request for authorization within 24 hours of admission to the Hospital as per the process under Section G.I.4 (a).

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

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

v. The Network Provider shall refund the deposit amount to You, barring a token amount to cover non-covered expenses once, the preauthorization is issued.

Note: Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy. For all Cashless authorizations, You will, be required to settle all non-admissible expenses, Co-payment and/or Deductibles (if applicable), directly with the Hospital.

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

- Claim Form Duly Filled and Signed
- Original pre-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 such cases, 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

i. If You have opted for a reimbursement of expenses, You may submit the following documents for reimbursement of the claim on our Mobile application or on or website (Details as mentioned in G.I.3). This can be submitted in our designated claims office (address as mentioned in G.I.3) at your own expense, no later than 15 days from the date of discharge from the Hospital.

All the following documents shall be required in original, except in case of deductible we require attested photocopy of below documents and settlement letter of previous insurer (partial payment cases).

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. The list of necessary claim documents to be submitted for reimbursement are as following:

a. Common claim documents required for all claims:

- Claim form duly signed
- Copy of photo ID of patient
- KYC documents of policyholder (Photo ID proof, address proof, recent passport size photograph)
- Cancelled cheque for NEFT payment of policyholder
- Payment receipt

b. Additional Claim documents required for below benefits:

S.No.	Name of Benefit	Name of Document
1	**In-Patient Hospitalization**	• Hospital Discharge summary • Operation Theatre notes/ ICP papers • Hospital Main Bill • Hospital Break up bill • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation • Pharmacy bills, prescription and invoices • Copy of FIR/Panchnama/ Police Inquest Report (if conducted) duly attested by the concerned Police Station in case of Accident.
2	**Day Care Treatment**	
3	**Donor Expenses**	
4	**AYUSH Treatment**	
5	**Sarathi**	
6	**Anant**	
7	**Surplus Benefit/Shakti**	
8	**Pre Hospitalization Medical Expenses**	• Pharmacy Bills • Diagnostic tests reports • Prescription in support of Pharmacy, Investigations • Consultation Papers
9	**Post Hospitalization Medical Expenses**	
10	**Road Ambulance**	• Original Bill as provided by Healthcare or Ambulance Service Provider • Certification of Medical Practitioner for necessity to use Ambulance
11	**Maternity & New Born Hospitalization Expenses**	• Obstetric history related information
12	**Domiciliary Hospitalization**	• Certificate from treating Medical Practitioner that condition of the InsuredPerson does not allow a Hospital transfer; or • Evidence that hospital bed was unavailable in nearest hospitals. • Final Bill and invoice • Nursing chart/TPR chart • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation Pharmacy bills, prescription and invoices
13	**Personal Accident Cover & Temporary Total Disablement**	**<u>In case of Accidental Death</u>** • MLC/ FIR report, Post Mortem Report if applicable and conducted • Original Death certificate issued by the office of Registrar of Birth & Deaths • Death summary issued by a Hospital • Identity proof of Nominee or Original Succession Certificate/ Original Legal Heir Certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased

		In case of Permanent Total Disablement, Permanent Partial Disablement and Temporary Total Disablement • MLC/FIR if applicable • Original treating Medical Practitioner's certificate describing the disablement; • Original Discharge summary from the Hospital; • Photograph of the Insured Person reflecting the disablement; • Prescriptions and consultation papers of the treatment; • Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board. • Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable; **Additional Documents under Temporary Total Disablement** • Attendance records or leave absence certificate from employer if required
14	**Air Ambulance**	• Original Bill as provided by Registered Ambulance Service Providerr • Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/ Injury warrants the Insured Person's requirement for Air Ambulance

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

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. 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) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.

b. We shall settle the payable claim amount after scrutinizing the claim documents.

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

G.I.7 Claim Assessment

a. We will assess all admissible claims under the Policy in the following progressive order –

i) Where a hospital room category opted for is higher than the eligible room category as specified in your Policy Schedule, the room rent for the applicable accommodation along with the 'Associated Medical Expenses' will be apportioned on pro rata basis. The following expenses shall not be a part of 'Associated Medical Expenses':.

(a). Cost of Pharmacy & consumables

(b). Cost of implant and medical device

(c). Cost of diagnostic test

ii) Any Voluntary Co-Payment shall be applicable on the amount payable after applying the section G.I.7.a (i).

iii) In case of a plan with deductible option, arrived payable claim amount will be assessed post the deductible (Daily deductible/Aggregate deductible as opted by You and mentioned in the Policy Schedule)

The Claim amount assessed under Section G.I.7 will be processed in following progressive order –

i. Base Sum Insured
ii. Guaranteed Cumulative Bonus (Gullak if opted and earned)
iii. Surplus Bonus or Shakti (if opted)
iv. Restoration (if opted and applicable)
v. Anant (if opted)

Claim Assessment for Fixed Benefits features ('Personal Accident Cover' under section D.III.1 and 'Temporary Total Disablement' under section D.III.2)

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 of policies with Monthly, Quarterly and Half-Yearly Premium Payment Mode:

In case of a claim (Cashless/Re-imbursement), 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 investigations 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 Pre-hospitalization and 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-hospitalization and Post-Hospitalization claim documents as mentioned in section G.I.5 either along with the In-patient Hospitalization papers or separately and process the same based on the merit of the claim, subject to Policy terms and conditions, derived on the basis of documents received.

G.I.10 Representation against Rejection:

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

G.I.11Payment Terms

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

ii. 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, 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.

iii. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Base Sum Insured including Guaranteed Cumulative Bonus i.e Gullak under section D.III.6 (if opted), Surplus Benefit/ Shakti under section D.III.10/D.III.11 (if opted), Restoration under section D.III.5 (if opted and available) and Anant under section D.III.12 (if opted and available) for that Insured Person is exhausted.

iv. All claims will be payable in India and in Indian rupees.

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

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

For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death, We will pay the nominee (as named in the Policy Schedule) and in the 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.

G.I.12 Health Check-up and Tele-Consultation

i. You or The Insured Person shall seek appointment by calling Our call centre.

ii. We will facilitate Your appointment and guide You to the nearest Network Provider for conducting the medical examination.

iii. Reports of the Medical Tests shall be emailed on your registered email-ID. It can also be collected directly from the centre.

G.I.13 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 follows:

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

i. **Cashless Hospitalization -** If the Insured Person avails cashless facility for hospitalization, the Insured, Network Provider will intimate us of the admission through a preauthorization request with all details and estimated amount for the hospitalization. The Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies.

ii. **Reimbursement Claim -** If the Insured Person is admitted and pays the entire bill, then files for a reimbursement claim, he/she may submit the documents for reimbursement of the claim through our mobile App or on our website or at our designated claims office(details as mentioned in Section G.I.3) at his/her own expense not later than 15 days from the date of discharge from the Hospital. All the documents shall be required in original, except in case of deductible we require attested photocopy of below documents and settlement letter of previous insurer (partial payment cases).

b. **Retail policy & group policy from the Company:**

i. **Cashless process:** If the insured needs to utilize the cashless facility for hospitalization, the insured/hospital will intimate the Company about the hospitalization through pre-authorization process. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/policies, even if the sum

insured is not exhausted. Subsequently, 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 manyseparate claims as no. of policies with theCompany, each with attached authorization letters & original documents for settlement to the Company. The Company will settle all the claims as per policy terms & conditions & authorization letter issued.

ii. **Reimbursement process:** In case the Insured gets admitted & pays the entire bill, & then files for reimbursement claim, he/she may submit the documents for reimbursement of the claim through our mobile App or on our website or at our designated claims office(details as mentioned in Section G.I.3) at his/her own expense not later than 15 days from the date of discharge from the Hospital. All the documents shall be required in original, except in case of deductible we require attested photocopy of below documents mentioned under section G.I.5 and settlement letter of previous insurer (partial payment cases).

G.II . Annexure – I:

Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:- bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir,Arera Hills Bhopal – 462001. Tel.: 0755 - 2769201 / 2769202/2769203 Email:- bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455/2596429/ 2596003 Email:- bimalokpal.bhubaneswar@cioins.co.in	State of Orissa.
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	States of Punjab, Haryana, (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044 - 24333668 / 24333678 Email:- bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011 - 46013992/ 23213504/ 23232481 Email:- bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh

GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205/2631307 Email:- bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Hyundai Showroom A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040 - 23376991 / 23376599 / 23328709 / 23325325/23312122 Email:- bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email:- bimalokpal.jaipur@cioins.co.in	State of Rajasthan.
KOCHI Office of the Insurance Ombudsman, 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	States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. TEL : 033 - 22124339 / 22124341 Email:- bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim, and Union Territories of Andaman and Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522 - 4002082 / 3500613 Email:- bimalokpal.lucknow@cioins.co.in	<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.
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	Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai

NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukkabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	States of Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.

G.III Annexure - II:

<table>
<tr><td>Title</td><td colspan="2">Description
Please refer to the Plan and Base Sum Insured you have opted to understand the available benefits under your plan in brief</td></tr>
<tr><td></td><td>Relationship Covered</td><td>Individual: Self, legally married spouse or live-in partner, son, daughter, father/ mother/ father-in-law/ mother-in-law/ son-in-law/ daughter-in-law/ grand-parents/ grandchildren/ uncle/ aunt/ nephew/ niece/ brother/ sister/ sister in-law/ brother in-law.
Floater: Self, legally married spouse or live-in partner, dependent children (natural / legally adopted), dependent parents/ parents-in-law</td></tr>
<tr><td>Your Coverage Details:</td><td>Identify your Plan</td><td>ManipalCigna Sarvah - Uttam</td></tr>
<tr><td rowspan="2">Basic Cover

This section lists the Basic benefits available on your plan Basic Cover</td><td>Identify your Opted Sum Insured (in ₹)</td><td>₹ 5 Lacs,₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 50 Lacs, ₹ 100 Lacs, ₹ 200 Lacs, ₹ 300 Lacs</td></tr>
<tr><td>In-patient Hospitalization (When you are hospitalized)</td><td>Covered up to Sum Insured
Room Rent: Covered up to Single Private AC Room
For ICU - Covered up to Sum Insured
This benefit shall also offer the below covers up to the limits mentioned:
i. Modern and Advanced Treatments: Covered up to Sum Insured
ii. HIV/AIDS & STD: Covered up to Sum Insured
iii. Mental Illness: Covered up Sum Insured
For ICD Codes mentioned below: Waiting Period of 24 months shall apply
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>F10</td><td>Alcohol related disorders</td></tr>
<tr><td>F20</td><td>Schizophrenia</td></tr>
<tr><td>F23</td><td>Brief psychotic disorders</td></tr>
<tr><td>F25</td><td>Schizoaffective disorders</td></tr>
<tr><td>F29</td><td>Unspecified psychosis not due to a substance or known physiological condition</td></tr>
<tr><td>F31</td><td>Bipolar disorder</td></tr>
<tr><td>F32</td><td>Depressive episode</td></tr>
<tr><td>F39</td><td>Unspecified mood [affective] disorder</td></tr>
<tr><td>F40</td><td>Phobic Anxiety disorders</td></tr>
<tr><td>F41</td><td>Other Anxiety disorders</td></tr>
<tr><td>F42</td><td>Obsessive-compulsive disorder</td></tr>
<tr><td>F44</td><td>Dissociative and conversion disorders</td></tr>
<tr><td>F45</td><td>Somatoform disorders</td></tr>
<tr><td>F48</td><td>Other nonpsychotic mental disorders</td></tr>
<tr><td>F60</td><td>Specific personality disorders</td></tr>
<tr><td>F84</td><td>Pervasive developmental disorders</td></tr>
<tr><td>F90</td><td>Attention-deficit hyperactivity disorders</td></tr>
<tr><td>F99</td><td>Mental disorder, not otherwise specified</td></tr>
</table></td></tr>
</table>

	Day Care Treatment	All Day Care Procedure covered up to Sum Insured.
	Pre - hospitalization Medical Expenses	Medical Expenses incurred during policy period covered up to 90 days before the date of hospitalization; covered up to the Sum Insured
	Post - hospitalization Medical Expenses	Medical Expenses covered up to 180 days post discharge from the hospital; covered up to the Sum Insured
	Domiciliary Hospitalization (Treatment at Home)	Covered up to the Sum Insured Pre and Post Hospitalization Expenses: 30 days each
	Road Ambulance (Reimbursement of Ambulance Expenses)	Covered up to the Sum Insured
	Donor Expenses (Hospitalization Expenses of the donor providing the organ)	Covered up to the Sum Insured • Pre & Post Hospitalization expenses (Up to 30 days each) of the donor • Cost towards donor screening once in a Policy year for successful transplant • Complications arising during hospitalization or up to 30 days from date of discharge – Covered up to 25% of Base Sum Insured subject to maximum of ₹2 Lacs, Over and above Base Sum Insured We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the organ.
	AYUSH Treatment	Covered up to the Sum Insured
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Tele-Consultation	Unlimited Tele-consultation with General Physician during the Policy Year
	Wellness Program	Rewards can be earned by completing activities specified under Our Healthy Life Management Program up to maximum of 20% of expiring base Premium (excluding Premium for optional covers other than Deductible, Voluntary Co-Payment, Twin Sharing, Extension of Specific Waiting Period, Rider and taxes as applicable). These earned Reward Points can be used as premium discount from 1st Renewal of the Policy. Carry forward of earned Reward Points shall not be allowed.
	Discount from Network Provider	Discount on Pharmacy, Diagnostics and Health Supplements offered by the Network Providers of ManipalCigna Health Insurance Company Limited

Optional Covers

This section lists the available optional covers under your plan and the limits under each of these options

Personal Accident Cover

Coverage under this option is available on Individual and Family Basis.
Min Age at Entry - 5 Years, Max Age at Entry 65 Years.
Relationships Covered - Self, Lawfully Wedded Spouse/Live-in Partner, Dependent Children, Dependent Parents/Parent in laws.
Individual Benefit Amount - ₹10L, ₹15L, ₹20L, ₹25L, ₹30L, ₹40L, ₹50L, ₹1Cr, ₹2Cr, ₹3Cr

Scope of Cover	% of PA Cover
Accidental Death (AD)	100% of the Personal Accident Cover Benefit Amount.
Permanent Total Disablement (PTD)	200% of Benefit Amount (if Death/ PTD) occurs due to an Accident while travelling as a fare paying passenger on a common carrier.
Permanent Partial Disablement (PTD)	% of Personal Accident Benefit Amount. (as defined in the Grid)
Family Cover Benefit Amount Eligibility	
Earning Member	As per the Benefit Amount Opted
Non-earning Spouse/ Live-in Partner	60% of the Benefit Amount of Earning member
Dependent Children /Parents/Par-ents-in-Laws	30% of the Benefit Amount, max up to ₹30Lacs

Age wise	Eligibility of Benefit Amount will be up to a maximum times of Annual Income of the Proposer or Earning member to be Insured. (as detailed below)
18-45	Max 20 times of the Gainful Annual Income
46- 60	
>60 above	Max 10 times of the Gainful Annual Income

Note:
i. Claims under Accidental Death, Permanent Total Disablement, and Permanent Partial Disablement shall be payable only in respect of accident occurring within India.

Temporary Total Disablement (TTD)

If the Insured Person suffers an injury due to an accident that occurs during the policy period and such Injury results in the Temporary Total Disablement of the Insured Person immediately after an Accident, We will pay fixed weekly benefit for the duration of the TTD.

Coverage Options
₹ 5K, ₹ 10K, ₹ 15K, ₹ 20K, ₹ 25K,₹ 50K, ₹ 1L per week.

Note:
i. Max No. of Weeks Covered - 100 in respect of any one Injury calculated from the date of commencement of the Temporary Total Disablement.
ii. Available only if Personal Accident Cover is opted.
iii. TTD Cover is available only for the earning members in India in the Policy.This benefit shall be applicable only for events or occurrences taking place within the geographical boundaries of India.

	Health Check Up	Available each policy year (including the first year), to all Adult insured persons who have completed 18 years of Age. • For Base Sum Insured of ₹5 lacs: Package 1 • For Base Sum Insured of ₹7.5 lacs and ₹10 lacs: Package 2 • For Base Sum Insured above ₹10 lacs: Package 3 The packages shall be offered on cashless basis only.
	Air Ambulance	Covered up to Sum Insured subject to maximum of ₹10 Lacs in addition to the Base Sum Insured, for expenses incurred on Air Ambulance
	Restoration (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for all illnesses and injury in addition to the Base Sum Insured Applicable for below covers only 1. D.I.1 - In-patient Hospitalization 2. D.I.2 - Day Care Treatment 3. D.I.3 - Pre - hospitalization Medical Expenses 4. D.I.4 - Post - hospitalization Medical Expenses 5. D.I.6 - Road Ambulance 6. D.I.7 - Donor Expenses 7. D.I.8 - AYUSH Treatment Restoration shall not get triggered for the 1st claim.
	Gullak (Guaranteed Cumulative Bonus)	We will provide an option to policyholder to get Guaranteed increase 100% of Base Sum Insured for each policy year up to the maximum of 1500% of Base Sum Insured irrespective of any claim made in the previous Policy Year.
	Maternity & New Born Hospitalization Expenses	**Maternity & New Born Hospitalization Expenses** a. **Maternity Cover** (up to maximum 2 deliveries or terminations) - Covered up to 20% of Base Sum Insured opted subject to a maximum of ₹5 Lac in addition to the Base Sum Insured opted. b. **New Born Baby** Coverage for the In-patient Hospitalization expenses of a new born up to the limit provided under Maternity Expenses. c. **First Year Vaccination** Covered as per national immunization program, up to the limit provided under Maternity Expenses. In Individual policies, we will offer Maternity Expenses to Adult Insured Male member as well. However, claim under this benefit shall be payable to the female spouse upon adding them as an Insured in the Policy. In such cases the applicable waiting period shall be as per the first inception of the Policy. **Note:** i. The female adult Insured Person should have been covered under the base Policy & Maternity Expenses for at least 36 months before availing this benefit. ii. The payment towards any admitted claim will be restricted to Maternity Sum Insured however any restored amount (if applicable) will not be available for coverage under this section. iii. Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit. iv. In case the Policy is migration/Portability, the Insured Person shall be entitled to continuity of waiting period only up to the Maternity Sum Insured available in previous policy subject to overall limit applicable under this benefit.

	Sarathi	If the Policyholder has opted for this optional cover, any condition, illness, complication, or ailment arising out of the below mentioned declared and accepted Pre-existing Diseases shall not be subject to the Pre-existing Disease Waiting Period. Such conditions shall be covered after the first 30 days from the Inception Date of the first Policy with Us: i. Asthma ii. Diabetes iii. Dyslipidemia iv. Obesity v. Hypertension Note – This optional cover is available only at inception (First Policy Year) and not at renewal. Once opted, it cannot be withdrawn in subsequent renewals.
	Room Rent Modification	The Policyholder shall be eligible to modify the room type category eligibility under the Policy as follows: Option 1: Any room; ICU Up to Sum Insured or Option 2: Twin Sharing AC room; ICU Up to Sum Insured
	Surplus Benefit	Additional 100% of Base Sum Insured, available from day 1 for 1st claim only,in each policy year. (Surplus Benefit and Shaktiare mutually exclusive)
	Shakti	The Insured Person can avail an additional 100% or 200% of the Base Sum Insured, as specified in the Policy Schedule, for all admissible claims in a Policy Year. Conditions: i. Applicable only after exhaustion of the Base Sum Insured. ii. Can be utilized for any number of admissible claims during the Policy Year iii. Any unutilized benefit amount will not be carried forward to the next Policy Year. iv. Shakti and Surplus Benefit are mutually exclusive.
	Anant Benefit	If the Insured Person opts for this Optional Cover, in the event of any Hospitalization related to Cancer, Heart, Stroke, Major Organ / Bone Marrow Transplant, or Accident, We will cover all Medical Expenses incurred under: • Section D.I.1 – In-patient Hospitalisation • Section D.I.2 – Day Care Treatment • Section D.I.8 – AYUSH Treatment without any Sum Insured limit, for unlimited times during the Policy Year. **Notes:** i. This cover can only be opted at the time of first Policy purchase and cannot be added at subsequent Renewals. ii. Available only with Base Sum Insuredof ₹10 Lacs. iii. This benefit applies at the Policy level, irrespective of Policy type (Individual/Family Floater). iv. Voluntary Co-payment, Deductible (if opted), and applicable Sub-limits shall also apply. v. This cover is applicable only for diagnosis, occurrences, and treatments taken within India.

	Deductible	Insured has option to choose either Option 1 – Aggregate Deductible of ₹10K, ₹25K, ₹50K, ₹1L, ₹2L, ₹3L, ₹4L, ₹5L or ₹10L or Option 2 – Per Day Deductible of ₹1K, ₹2K, ₹3K, ₹4K or ₹5K per day of Hospitalization on all admissible claims
	Voluntary Co-Payment	Options of 10%, 20% or 30% will be applicable on each and every claim
	Coverage for Non-Medical Items and Durable Medical Equipment	**1. Non-Medical Items** Covered up to the Sum Insured opted under the policy, in case of In-patient Hospitalization or Day Care Treatment or Domiciliary hospitalization. **2. Durable Medical Equipment** Covered up to ₹1 Lac in case, prescribed during hospitalization or within 30 days post-discharge. (CPAP Machine, BPAP Machine, Ventilator, Wheelchair, Prosthetic Device, Suction Machine, Commode Chairs, Infusion Pump, Continuous Passive Motion Devices In Case Of Knee Replacement, Oxygen Concentrator
	Extension of Specific Disease Waiting Period	By opting for this optional cover, the Insured Person agrees to extend the waiting period for Specified Diseases or Procedures (as mentioned under Section E.I.2) to 36 months. Note: i. This optional cover is available only at inception of the Policy (first Policy Year) and cannot be availed at the time of renewal. It is not available for ported or migrated policies. ii. Once this benefit is opted cannot be opted out in subsequent renewals. iii. This benefit will apply at the Policy level, irrespective of Policy type.
Add on cover (Rider) This section lists the Add on cover available under your plan	ManipalCigna Health 360- OPD	Coverage available for OPD as per package opted.

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

G.IV Annexure III

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

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