MANIPALCIGNA SARVAH - PRATHAM

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 a disease, 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 empanelled 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 in the 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 pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The Grace Period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

28. 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.

29. 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.

30. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by 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.

31. **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.

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

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

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

35. **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.

36. **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.

37. **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.

38. **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.

39. **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.

40. **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.

41. **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.

42. **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.

43. **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.

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

45. **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.

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

C.II. Specific Definitions

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

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

6. **Covered Relationships** shall include 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.

7. **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.

8. **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.

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

10. **Indian Resident** means an individual will be considered to be resident of India, if he is in India for a period or periods amounting in all to one hundred and eighty-two days or more, in the immediate preceding 365 days.

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

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

13. **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.

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

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

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

17. **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), including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

18. **Single Private AC Room** means a single Hospital room with any rating and of most economical category available at the time of Hospitalization with/without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. This excludes a suite or higher category.

19. **Specified Illness** means

i. **Cancer -** Cancer is defined as a malignant tumour 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 tumours.

ii. **Heart**

a. **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.

b. **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.

c. **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.

d. **Rheumatic Heart Disease** is a chronic inflammatory condition leading to permanent damage to the heart valves, resulting from rheumatic fever.

e. **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.

f. **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.

g. **Cardiomyopathy (Heart Muscle Disease)** is a group of diseases that affects myocardium(heart muscle), leading to impaired cardiac functions (contractions & relaxations)

Exclusions:

a) Heart diseases caused by illicit drug use, substance abuse, Alcohol or non-prescribed medications.

b) Self-inflicted injuries or conditions resulting from non-compliance with medical advice.

c) Congenital heart diseases

d) Hospitalization for Hypertension and associated illness unless impacting the Heart & resulting in any condition covered under plan.

iii. **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.

iv. **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.

20. **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the amount representing Our maximum liability for any or all claims during the Policy Period specified in the Policy Schedule separately in respect of that Insured Person.

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

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

21. **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.

22. **Twin Sharing Room** means a Hospital room where at least two patients are accommodated at same time. Such room shall be the most basic and most economical of all accommodations available as twin sharing room in that Hospital.

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

24. **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. Inpatient Hospitalization

We will cover Medical Expenses of an Insured Person in the case of Medically Necessary Hospitalization arising from Specified disease/ Illness such as Cancer, Heart, Stroke, & Major Organ/Bone Marrow Transplant, as defined under section C.II 19, provided such Hospitalization is for more than 24 consecutive hours and the admission date is within the Policy Year.

We will pay Medical Expenses as shown in the Policy Schedule for:

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) charges for accommodation,
c. operation theatre charges,
d. fees of Medical Practitioner and Surgeon,
e. anesthetist fees,
f. qualified nurses fees,
g. specialists fees,
h. cost of diagnostic tests,
i. medicines,
j. drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and used intra operatively during a Surgical Procedure.

Room category coverage under this plan will be up to Single Private AC Room, subject to a maximum of the Sum Insured opted. For ICU accommodation, we will cover up to the Sum Insured opted.

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

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

The following 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, for Specified disease/ Illness such as Cancer, Heart, Stroke, & Major Organ/ Bone Marrow Transplant, as defined under section C.II 19, within a policy year within a Policy Year.

a. HIFU (High intensity focused ultrasound)
b. Oral chemotherapy
c. Immunotherapy - Monoclonal Antibody to be given as injection
d. Robotic surgeries
e. Stereotactic radio surgeries
f. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

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 payment of Medical Expenses for an Insured Person in the case of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization due to advancement in technology. This 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 of this Policy, provided that:

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

b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure undertaken by the Insured Person as Day Care Treatment.

c. We will not cover any OPD Treatment and diagnostic service under this benefit.

d. Such Day Care Treatment shall be related to Specified disease/Illness such as Cancer, Heart, Stroke, & Major Organ/Bone Marrow Transplant, as defined under section C.II 19.

e. Coverage will also include pre and post hospitalization expenses up to the limit specified in the Policy Schedule of this Policy.

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

D.I.3 Pre-hospitalization Medical Expenses

We will cover, on a reimbursement basis, the Medical Expenses of the Insured Person incurred due to a disease/Illness or Injury that occurs during the Policy Year immediately prior to the Insured Person's date of Hospitalization, up to the limits specified in the Policy Schedule, provided that a claim has been admitted as 'In-patient Hospitalization' under section D.I.1 or 'Day Care Treatment' under section D.I.2 and is related to the same illness or 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.4 Post-hospitalization Medical Expenses

We will cover, on a reimbursement basis, the Medical Expenses of an Insured Person incurred due to a disease/ Illness or Injury that occurs during the Policy Year immediately following the discharge of the Insured Person from the Hospital, up to the limits as specified in the Policy Schedule. This coverage is provided, given that a claim has been admitted as the 'In-patient Hospitalization' under section D.I.1 or 'Day Care Treatment' under section D.I.2 and is related to the same illness/condition.

All claims under this benefit can be made as per the process defined under section G.I.5 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 of this Policy, for a disease/Illness or Injury that would normally require Hospitalization but is 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 a Hospital transfer; or

ii. Hospital bed was unavailable.

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

a) We will pay for Pre-hospitalization and Post-hospitalization Medical Expenses for up to 30 days each.

b) Restoration of Sum Insured shall not be available under this benefit

c) Such Domiciliary Hospitalization shall be related to medical treatment towards Specified disease/Illness such as Cancer, Heart, Stroke, & Major Organ/Bone Marrow Transplant, as defined under section C.II 19.

d) We shall not be liable under this Policy for any Claim in connection with or in respect of rheumatic heart disease.

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 provide reimbursement for Reasonable and Customary expenses up to the Sum Insured as specified in the Policy Schedule of this Policy. These expenses are 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 the Policy in case of an Emergency, necessitating the Insured Person's admission to the nearest Hospital. The necessity of using an Ambulance must be certified by the treating Medical Practitioner.

a. Reasonable and Customary expenses shall include:

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

ii. the cost of moving the Insured Person to a better Hospital facility due to lack of super specialty treatment in the existing Hospital.

b. Payment under this cover is subject to a claim being admissibleunder section D.I.1 'In-patient Hospitalization' or under section D.III.1 'Accidental Hospitalization' (if opted), 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 In-patient Hospitalization Medical Expenses for the donor for harvesting the organ, up to the Sum Insured as specified in the Policy Schedule of this Policy, subject to the conditions:

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

b. We have admitted a claim under section D.I.1- towards 'In-patient Hospitalization or under section D.III.1 towards Accidental Hospitalization (if opted).

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

   i. Any Pre or Post-hospitalization Medical Expenses, up to 30 days each.

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

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

   iv. Any complication in respect of the donor, consequent to harvesting, which arise during Hospitalization or up to 30 days from the date of discharge of the donor, up to the limits specified in the Policy Schedule of this Policy. This benefit shall be over and above the Sum Insured.

We will not cover expenses for the Donor associated with the acquisition of the organ.

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 as specified in the Policy Schedule, for an Insured Person in case of Medically Necessary Treatment taken as In-patient Hospitalization or Day Care Treatment for AYUSH Treatment. This applies to Illness or Injury related to Specified disease such as Cancer, Heart, Stroke, & Major Organ/Bone Marrow Transplant, as defined under section C.II 19, that occurs during the Policy Year. Coverage is available, provided the Insured Person has undergone these treatment in an AYUSH Hospital or AYUSH Day Care Center.

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

i. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation.

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

D.II Value added covers

D.II.1 Tele-Consultation

An Insured Person may avail tele-consultations with our General Physician through our network in India for the unlimited times. For the purpose of this benefit, tele-consultation shall mean consultation provided by a Medical Practitioner through various mode of communication available through tele/chat mode.

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 wherein you need to complete number of steps per day, as outlined in the table below, you can improve your well-being and earn rewards.

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 should fall within the first nine (9) months of each Policy Year. Activities undertaken towards this benefit during the last three (3) months of

the Policy Year will not be considered for reward calculation.

ii. This wellness program is available only for the adult members aged 18 years and above. However, in a floater policy, this program shall be available only to the independent adult members and will not be available to dependent children.

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

iv. In a floater policy the above reward percentage would be divided 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 (Excluding optional cover/ Rider and taxes).

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

vi. 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.11, 'Voluntary Co-Payment' under section D.III.12 and Twin sharing room option of 'Room Rent Modification' under section D.III.9, riders and taxes) 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.11, 'Voluntary Co-Payment' under section D.III.12 and Twin sharing room option of 'Room Rent Modification' under section D.III.9, riders and taxes) for 2 years or 3 years as applicable.

vii. Each earned reward point will be valued at 1 Rupee. Accrued rewards can be redeemed against payable premium (excluding premium for Optional covers, Riders and Taxes) from the 1st Renewal of the Policy.

viii. The earned reward points can be utilized as a discount in the renewal premium due immediately after accrual. Carry forward earned reward points shall not be allowed.

ix. Redemption against renewal premium will be available only at the time such renewal is due. Any earned rewards 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)	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)	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 (Excluding optional covers/ Rider and taxes)	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)	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 wellness program will be communicated via SMS, email and the program-specific phone/web application. Details about reward points will be available on the program app (if any) or would be shared through SMS and/or Renewal Notice which would be sent to customers.

D.II.3 Discount from Network Providers

The Insured Person can avail discounts on diagnostics, pharmacy and health supplements offered through our Network Providers.

D.III. Optional covers

The following optional covers shall apply under the Policy for an Insured Person if specifically mentioned on the Policy Schedule and shall apply to all Insured Persons under a single policy without any individual selection except the benefit 'Personal Accident Cover' under section D.III.2 and 'Temporary Total Disablement' under section D.III.3.

D.III.1 Accident Hospitalization Cover

If the Insured Person has opted for this Optional Cover, and if there is any hospitalization related to accidental injury occurring during the Policy Year, We will cover medical expenses related to all benefits covered under Section D such as Inpatient Hospitalization (Section D.I.1), Day Care Treatment (Section D.I.2), Pre Hospitalization Medical Expenses (Section D.I.3), Post Hospitalization Medical Expenses (D.I.4), Domiciliary Hospitalization (Section D.I.5), Road Ambulance (Section D.I.6), Donor Expenses (Section D.I.7) & AYUSH Treatment (Section D.I.8), subject to the limits specified in the Policy Schedule of this policy.

D.III.2 Personal Accident Cover

If an Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and if such Injury solely and directly results in the Insured Person's death or disablement within 365 days of the Accident, We will pay the corresponding benefits as specified below to You, the Insured Person, or the Nominee, as applicable.

D.III.2.A Accidental Death (AD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such 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 Sum Insured as specified in the Policy Schedule.
- 200% of the opted Sum Insured if such death occurs while the Insured Person is a fare-paying passenger on a common carrier.

Once a claim has been accepted and paid under this benefit, cover will automatically terminate for that Insured Person.

D.III.2.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 specified in the table below within 365 days from the date of the Accident, We will pay:

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

Type of Permanent Total Disablement
i. Total and irrecoverable loss of sight of both eyes
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.13)

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, then no amount will be payable under this benefit; however, it will be payable under 'Accidental Death' under section D.III.2.A above, provided it is payable as per the coverage under section D.III.2 and such intimation of death has been made to Us.

d. If We have admitted a claim for Permanent Total Disablement in accordance with this benefit, then We shall not be liable to make any payment under the Policy on the death of the Insured Person if the Insured Person subsequently dies.

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

D.III.2.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 specified in the table below within 365 days from the date of the Accident, We will pay the amount specified in the table below:

Table of Benefits	Percentage of Sum Insured 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 a disability certificate issued by a Civil Surgeon or the equivalent appointed by the District/State or Government Board; and

b. The Permanent Partial 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, then no amount will be payable under this benefit; however, it will be payable under 'Accidental Death' under D.III.2.A above, provided it is payable as per the coverage under section D.III.2 and such intimation of death has been made to Us.

d. In case the Insured Person suffers a loss not mentioned in the table above, then Our medical advisors will determine the degree of disablement and the amount payable, 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.2.B and 'Permanent Partial Disability' under section D.III.2.C in respect of the Insured Person, and the total amount paid or payable under those claims is cumulatively greater than or equal to the opted Sum Insured for that Insured Person.

f. Once a claim has been accepted and paid under this benefit, cover under this Policy shall be reduced to the extent of payment made under Permanent Partial Disability for that Insured Person.

Notes:

i. At least one earning member must be covered if Personal Accident cover is opted.

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

iii. Claims under Accidental Death, Permanent Total Disablement, and Permanent Partial

Disablement shall be subject to claims within India.

iv. In the event of death or discontinuation of the earning member, 'Personal Accident Cover' would be allowed to continue for non-earning member at the time of Renewal.

v. 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 the coverage amount for them for will 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.3 Temporary Total Disablement (TTD)

If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and if 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 paid for the duration of the Temporary Total Disablement.

For the purpose of this benefit, 'Temporary Total Disablement' means a disablement of an Insured Person such that he or she is totally disabled from engaging in any employment, occupation, or business for remuneration or profit, or unable to perform his or her duties of any description whatsoever on a temporary basis and a disability certificate is issued by the treating Doctor or Civil Surgeon or the equivalent appointed by the District/ State or Government Board.

Note:

i. TTD benefit can only be opted if the 'Personal Accident Cover' (Section D.III.2) is opted.

ii. TTD benefit is available only for the earning member in the Policy.

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.4 Health Check Up

We provide a comprehensive Health Check-Up to all Insured Persons covered as adults (excluding dependent children in floater policy), as listed in the eligibility table below. Health Check-Ups are available irrespective of their claim status under the Policy and will be arranged by us at 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	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, CBC-ESR, 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.

D.III.5 Air Ambulance

We will reimburse the Reasonable and Customary expenses incurred for the transportation of an Insured Person to the nearest Hospital or for moving the Insured Person to and from healthcare facilities within India by an Air Ambulance, provided that:

i. The Air Ambulance is used in the case of an Emergency life threatening health condition of the Insured Person, which requires immediate and rapid ambulance transportation to the Hospital or a medical centre that ground transportation cannot provide;

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 that can provide medical care in flight and should have medical equipment to monitor vitals and treat the Insured Person suffering from an Illness/Injury, including but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;

iv. Restoration of the Sum Insured shall not be available under this benefit.

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

vi. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the need for an Air Ambulance;

vii. Payment under this cover is subject to a claim being admissible under Section D.I.1 'In-patient Hospitalization' or Section D.I.2 'Day Care Treatment', for the same Illness/Injury.

The benefit under this cover is payable up to the limits specified in the Policy Schedule, subject to a maximum of ₹10 Lacs in a Policy Year, and this is over and above the Sum Insured.

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

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

D.III.6 Restoration of Sum Insured

We will provide a 100% restoration of the Sum Insured any number of times in a Policy Year, whether the illness/condition is unrelated or the same, provided that:

i. The Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak if opted & earned), is insufficient as a result of previous claims in that Policy Year.

ii. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under section D of the Policy and shall not apply to the first claim in the Policy Year. Restoration of the Sum Insured will only be provided for coverage under 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' and section D.III.13 'Coverage for Non-Medical Items and Durable Medical Equipment's' (if opted).

iii. The Restored Sum Insured will not be considered while calculating the Guaranteed Cumulative Bonus (Gullak if opted).

iv. Such restoration of the Sum Insured will be available any number of times during a Policy Year to each insured in the case of an Individual Policy and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

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

vi. If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to the subsequent Policy Year.

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

a) Sum Insured

b) Guaranteed Cumulative Bonus (Gullak if opted and earned)

c) Surplus Benefit (Applicable for 1st Claim if opted)

d) Restored Sum Insured (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.7 Gullak (Guaranteed Cumulative Bonus)

We will increase Your Sum Insured by 100% as specified in the Policy Schedule at the end of the Policy Year, provided the Policy is renewed with Us without any break.

Note:

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

ii. The Guaranteed Cumulative Bonus (Gullak Amount) will not exceed 1000% of the Sum Insured under the Current Policy with Us under any circumstances.

iii. Any Guaranteed Cumulative Bonus (Gullak Amount) 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 the expiring Policy is renewed with Us on a Family Floater basis, the Guaranteed Cumulative Bonus (Gullak Amount) carried forward to the renewed policy will be lowest percentage of the Guaranteed Cumulative Bonus (Gullak Amount) applicable to the lowest Sum Insured of the last policy year amongst all the expiring polices being merged.

v. Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/Individual policies, the Guaranteed Cumulative Bonus (Gullak Amount) will be apportioned to the Renewed Policies in proportion to the Sum Insured of each Renewed Policy.

vi. Reduction in Sum Insured: If the Sum Insured is reduced at the time of Renewal, the applicable Guaranteed Cumulative Bonus (Gullak Amount) will be calculated on the revised Sum Insured on pro-rata basis.

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

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

ix. This Guaranteed Cumulative Bonus (Gullak Amount) shall not be available for claims made for Value Added Covers (Section D.II) and under section D.III.5 '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.8 Sarathi

If the Insured Person has opted for this Optional Cover, any hospitalization related to Cancer, Heart, Stroke, or Major Organ/Bone Marrow Transplant, as defined under Section C.II.19, caused due to condition, illness, complication or ailment arising out of any of the below mentioned conditions declared and accepted as part of a Pre-Existing Disease shall not be subject to the Pre-Existing Disease waiting period. These condition will 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 during the first Policy Year and cannot be availed during renewal. Once this optional cover is opted for, it cannot be opted out in the subsequent renewal.

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 covered under 'In-patient Hospitalization' to either "Any Room" or "Twin Sharing AC room" as per your choice. This coverage will be provided up the Sum Insured specified in the Policy schedule of this Policy.

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

D.III.10 Surplus Benefit

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

i. The Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak if opted and earned) is insufficient for the first claim in every 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 every Policy Year shall not be carried forward to subsequent claims in the same Policy Year or next Policy Year.

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

D.III.11 Deductible

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

a. Aggregate Deductible - When an Aggregate Deductible is selected, the deductible amount will be applied for each Policy Year on the aggregate of all claims in that Policy Year.

b. Daily Deductible - When a Daily Deductible is selected, 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 during Renewal of the Policy.

ii. Opting out of the Deductible may be subject to underwriting.

iii. For Aggregate deductible other than ₹10,000 or ₹25,000, if the insured opt out during any renewal, a fresh waiting period will be applied for this enhanced limit from the effective date of such enhancement.

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

v. Deductible opted shall apply on all claims other than mentioned under section D.III.2 'Personal Accident Cover', section, D.III.3 'Temporary Total Disablement' section D.III.4 'Health Check-Ups', section D.III.5 'Air Ambulance' and Value Added Cover (section D.II).

For the purpose of calculating 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.12 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, it is agreed that We will only pay 90% or 80% or 70% of any amount that We assess (payable amount) for the payment or reimbursement in respect of any claim under the Policy made by that Insured Person and the balance will be borne by the Insured Person.

Voluntary Co-payment shall apply to all sections other than mentioned under section D.III.2 Personal Accident Cover', section D.III.3 'Temporary Total Disablement', section D.III.4 'Health Check-Ups' section D.III.5 'Air Ambulance' and Value Added Cover (section D.II). Voluntary Co-Payment if opted shall apply in addition to any other co-payment applicable in this Policy.

D.III.13 Coverage for Non-Medical Items and Durable Medical Equipment's

D.III.13.A Non-Medical Items

The cover is available subject to the claim being admissible under 'In-patient Hospitalisation' under section D.I.1 or 'Day Care Treatment' under section D.I.2 or 'Domically Hospitalization' under section D.I.5, and 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 be applicable for this benefit.

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

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

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

D.III.13.B Durable Medical Equipment

We will cover the expenses towards the cost of buying 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 base Policy, and the expenses on Durable Medical Equipment are related to the same Illness/ Injury.

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

iii. Any purchase/renting of the Durable Medical Equipment should be done 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 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.

E. Exclusions

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

E.I. Standard Exclusions

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

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

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

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

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

E.I.2 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 sum insured subsequently.

E.I.3 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.4 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.5 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.6 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.7 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.8 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.9 Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

E.I.10 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.11 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.12 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.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 the list of acceptable Medical Ailments listed under the Underwriting Manual of the Product, depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

E.II.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 a disease, 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 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.13 All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment. For complete list of Non-medical expenses, please refer to the Annexure III List - I "Items for which Coverage is not available in the Policy" subject to conditions mentioned in D.III.13 'Coverage for Non-Medical Items and Durable Medical Equipment's'.

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

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

E.III.1. 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 Sum Insured, the exclusion shall apply afresh to the extent of Sum Insured increase.

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

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

(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. 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.

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

E.III.3. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment.

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

F. General Terms and Clauses

F.I. Standard General Terms and Clauses

F.I.1. Disclosure of Information

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

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

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

F.I.2 Condition Precedent to Admission of Liability

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

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

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

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

F.I.4 Complete Discharge

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

F.I.5 Multiple Policies

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

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

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

F.I.6 Fraud

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

Any amount already paid against claims 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 by providing 7 day's written notice. In such an event, the company shall refund the premium for the unexpired policy period as detailed below:

A. Policy Tenure of 1 Year:

1. If no claim has been made during the policy

period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of the cancellation request will be considered as the expiry date of coverage.

2. If a claim has been made during the Policy period, no refund will be given to the Policyholder.

Illustration:

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

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

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

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

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

B. If Policy Tenure is more than 1 years:

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

Illustration:

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

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

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

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

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 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 in waiting periods as per IRDAI guidelines on migration.

F.I.9 Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire Policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal

date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/ Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Portability

F.I.10 Renewal of Policy

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

i. The Company shall give notice for Renewal at least 30 days in advance from the Policy due date.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iv. At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period of 30 days, to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.
v. No loading shall apply on Renewals based on individual claims experience.

F.I.11 Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as 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 Sums Insured of the first Policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of Sums Insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

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

If the insured person has opted for Payment of Premium on an Instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, 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”, 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 Insured Person shall be notified three months before the changes are effected.

F.I.15 Free Look period

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

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

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

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

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

F.I.16. Redressal of Grievance

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

Email: customercare@manipalcigna.com,

Senior Citizens may write to us at:

seniorcitizensupport@manipalcigna.com

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

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

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

'The Grievance Cell, ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

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

or

Email: headcustomercare@manipalcigna.com.

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

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

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

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

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

F.I.17. Nomination

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

F.II. Specific Terms and Clauses

F.II.1. Material Change

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

F.II.2 Alterations in the Policy

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

F.II.3 Change of Policyholder

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

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

F.II.4 No Constructive Notice

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

F.II.5 Geography

The geographical scope of this Policy applies to events within India. 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. 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 90 days prior to date of such revision or modification.

vii. Alterations like increase/decrease in 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 Sum Insured on Renewal. The terms and conditions of the existing Policy will not be altered.

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

ix. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 36 consecutive months 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.2 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 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 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 CKYC documents.

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 **Districts in Punjab:** Amritsar, Gurdaspur **Others:** Kolkata, Rewari, Jind, Jhunjhunu, Patna
Zone 2	**Rest of the Bihar State** **Districts in Andhra Pradesh/Telangana:** Ananthapur, Bapatla, Gadwal, Guntur, Jagtial, Kamareddy, Karimnagar, Kurnool, Mahabubnagar, Mancherial, Medak, Nalgonda, Nellore, Nizamabad, Peddapalli, Rangareddy, Suryapet, Wanaparthy **Districts in Punjab:** Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, Mohali, Patiala **Districts in Maharashtra:** Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad **Districts in Uttar Pradesh:** Banda, Fatehpur, Kanpur **Others:** Chennai, Bangalore, Wayanad, Chandigarh, Panchkula, Bokaro, Dhanbad
Zone 3	**Assam State, 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:** Chikkamagaluru, Dakshina kannada, Chikkaballapur, Kolar, Tumakuru, Udupi **Districts in Rajasthan:** Ajmer, Dausa, Dholpur, Jaipur, Karauli, Sawai madhopur, Tonk, **Districts in Tamilnadu:** Coimbatore, Erode, Kanchipuram, Karur, Krishnagiri, Tiruppur, Tiruvallur **Others:** Dehradun, Raipur
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 Loadings & Special Conditions

We may apply a risk loading on the premium payable (excluding Statutory Levis and Taxes) or Special Conditions on the Policy based upon the health status of the persons proposed for insurance and declarations made in the Proposal Form. These loadings will be applied from inception date of the first Policy including subsequent Renewal(s) with Us. There will be no loadings based on individual claims experience.

We may apply a specific sub-limit on a medical condition/ailment depending on the past history and declarations or additional waiting periods (a maximum of 36 months from the date of inception of first policy) on Pre-Existing Diseases as part of the special conditions on the Policy.

We shall inform You about the applicable risk loading or special condition through a counter offer letter or through an electronic mode, as the case may be and You would need to revert with consent and 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.11 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.12 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.13 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.14 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.15 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, shall be the condition precedent to the admissibility of the claim.

Completed claim forms and processing documents must be furnished to Us within the stipulated timelines for all reimbursement claims. Failure to furnish this documentation within the 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 are 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.

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

G.I.4 Cashless Facility

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

a) For Planned Hospitalization:

i. The Insured Person should approach the Network Provider or Common empanelment of hospital/healthcare providers for Hospitalization for medical treatment at least 48 hours prior to admission to the Hospital.

ii. The Network Provider or Common empanelment of hospital/healthcare providers will issue the request for an authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDA.

iii. The Network Provider or Common empanelment of hospital/healthcare providers 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 with confirmed diagnosis of any conditions covered under plan from the Network Provider or Common empanelment of hospital/healthcare providers, 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 or Common empanelment of hospital/ healthcare providers. Wherever additional information or documents are required, We will call for the same from the Network provider or

Common empanelment of hospital/ healthcare providers and, upon satisfactory receipt of the necessary documents, the authorization will be issued. All authorizations will be issued within a period of 1 hour from the receipt of complete documents.

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 or Common empanelment of hospital/healthcare providers shall obtain a fresh authorization letter from Us in accordance with the process described under G.I.4 (a) above.

At the time of discharge:

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

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

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

b) In case of Emergency Hospitalization

i. The Insured Person may approach the Network Provider or Common empanelment of hospital/ healthcare providers for Hospitalization for medical treatment.

ii. The Network Provider or Common empanelment of hospital/healthcare providers shall forward the request for authorization and medical information with confirmed diagnosis of any condition covered under plan 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 or Common empanelment of hospital/healthcare providers 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, limb-saving, sight saving, Emergency medical attention requiring situation.

v. The Network Provider or Common empanelment of hospital/healthcare providers shall refund the deposit amount to You, barring a token amount to cover non-covered expenses once, the pre-authorization is issued.

Note: Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital or Common empanelment of hospital/ healthcare providers as specified by Insurance Council 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 or Common empanelment of hospital/healthcare providers will send the claim documents along with the invoice and discharge voucher duly signed by the Insured Person, directly to us. The following claim documents should be submitted to Us within 15 days from the date of discharge from Hospital -

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

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

There can be instances where We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility. In 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 to Our branch or head office 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 (Photo ID proof, address proof, recent passport size photograph)
- Cancelled cheque for NEFT payment
- 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	**Pre Hospitalization Medical Expenses**	• Pharmacy Bills • Diagnostic tests reports in relation to admitted hospitalization expenses • Prescription in support of Pharmacy, Investigations
6	**Post Hospitalization Medical Expenses**	
7	**Road Ambulance**	• Original Bill as provided by Healthcare or Ambulance Service Provider • Certification of Medical Practitioner for necessity to use Ambulance
8	**Domiciliary Hospitalization**	• Certificate from treating Medical Practitioner that condition of the Insured Person 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

9	**Personal Accident Cover** **-AD** **-PTD** **-PPD** **&** **Temporary Total Disablement (TTD)**	**In case of Accidental Death (AD)** • 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 (PTD), Permanent Partial Disablement (PPD) and Total Temporary Disablement (TTD)** • Original treating Medical Practitioner's certificate describing the disablement; • MLC/FIR if applicable • 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 (TTD)** • Attendance records or leave absence certificate from employer if required
10	**Air Ambulance**	• Original Bill as provided by Registered Ambulance Service Provider • 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
11	**Sarathi**	• As specified in in-patient Hospitalization

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

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

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

G.I.6. Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents, and notify the relevant stakeholders (such as Network Provider or Common empanelment of hospital/healthcare providers) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.

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

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

G.I.7 Claim Assessment

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

a. For Plans without Deductible Option

i) Where a room accommodation is opted for higher than the eligible room category under the plan,

the room rent for the applicable accommodation will be apportioned on pro rata basis. Such apportioned amount will apply to all "Associated Medical Expenses". [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)]

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

b. For Plans with Deductible Option

i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned on pro rata basis. Such apportioned amount will apply to all "Associated Medical Expenses". [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)]

ii) Arrived payable claim amount will be assessed against the deductible (Daily deductible Aggregate as opted by You).

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

i. Sum Insured
ii. Guaranteed Cumulative Bonus (Gullak if opted and earned)
iii. Surplus Bonus (if opted)
iv. Restored Sum Insured (if opted and applicable)

Claim Assessment for Fixed Benefits features ('Personal Accident Cover' under section D.III.2 and 'Temporary Total Disablement' (TTD) under section D.III.3)

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

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

In case of a claim (Cashless/Re-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 investigation shall be conducted on case to case basis and will be concluded accordingly. Any verification or investigation will be carried out by individuals or entities authorized by Us, and the cost of such verification/investigation will be borne by Us

G.I.9 Pre and Post-hospitalization claims

You should submit the Pre 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 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.11 Payment Terms

i. The Sum Insured opted under the Policy shall be reduced by the amount payable/paid under the benefit(s), and the balance shall be available as the Sum Insured for the unexpired Policy 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 Sum Insured including Guaranteed Cumulative Bonus i.e. Gullak under section D.III.7 (if opted), Surplus Benefit under section D.III.10 (if opted) and Restoration of Sum Insured under section D.III.6 (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 or Common empanelment of hospital/healthcare providers, whose discharge would be complete and final.

For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death,

We will pay the nominee (as named in the Policy Schedule) and in 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 can 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, or common empanelment of hospital/healthcare provider will intimate us of the admission through a pre-authorization request with all details and estimated amount for the hospitalization. The Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies.

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

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 many separate claims as no. of policies with the Company, 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, they will have to intimate the Company of the admission 48 hours before admission for planned admissions & within 24 hours post hospitalization for emergency hospitalization along with all the policy numbers.

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

G.II . Annexure – I:
Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:- bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 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 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 - 23237539 Email:- bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh

GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Email:- bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040 - 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	State of Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai and Thane

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

G.III Annexure - II:

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief	
	Relationship Covered	**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
Your Coverage Details:	**Identify your Plan**	**ManipalCigna Sarvah -Pratham**
Basic Cover This section lists the Basic benefits available on your plan Basic Cover	Identify your Opted Sum Insured (in ₹)	₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs, ₹100 Lacs, ₹200 Lacs, ₹300 Lacs
	In-patient Hospitalization (When you are hospitalized)	Covered up to Sum Insured Room Rent: Covered up to Single Private AC Room For ICU - Covered up to Sum Insured. Listed Modern and Advanced Treatments: Up to Sum Insured
	Day Care Treatment	All Day Care Procedure related to specified disease/illness, covered up to Sum Insured.
	Pre-hospitalization Medical Expenses	Medical Expenses 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 tp 25% of SI subject to maximum of ₹2 Lacs, Over and above SI 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

<table>
<tr><td rowspan="3">Value Added Covers

This section lists the additional value added benefits that are available along with your plan</td><td>Tele-Consultation</td><td>Unlimited Tele-consultation with General Physician during the Policy Year</td></tr>
<tr><td>Wellness Program</td><td>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, Rider and taxes).
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.</td></tr>
<tr><td>Discount from Network Provider</td><td>Discount on Pharmacy, Diagnostics and Health Supplements offered by the Network Providers of ManipalCigna Health Insurance Company Limited</td></tr>
<tr><td rowspan="2">Optional Covers

This section lists the available optional covers under your plan and the limits under each of these options</td><td>Accidental Hospitalization</td><td>Covered up to Sum Insured</td></tr>
<tr><td>Personal Accident Cover</td><td>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 Sum Insured - ₹10L, ₹15L, ₹20L, ₹25L, ₹30L, ₹40L, ₹50L, ₹1Cr, ₹2Cr, ₹3Cr
Family Cover Sum Insured Eligibility
<table>
<tr><td>Earning Member</td><td>As per the Sum Insured Opted</td></tr>
<tr><td>Non-earning Spouse/ Live-in Partner</td><td>60% of the Sum Insured of Earning member</td></tr>
<tr><td>Dependent Children /Parents/ Parents-in-Laws</td><td>30% of the Sum Insured, max up to ₹30Lacs</td></tr>
</table>
<table>
<tr><td>Age wise</td><td>Eligibility of Sum Insured will be up to a maximum times of Annual Income of the Proposer or Earning member to be Insured. (as detailed below)</td></tr>
<tr><td>18-45</td><td rowspan="2">Max 20 times of the Gainful Annual Income</td></tr>
<tr><td>46- 60</td></tr>
<tr><td>>60 above</td><td>Max 10 times of the Gainful Annual Income</td></tr>
</table>
Note:
i. At least one earning member must be covered if Personal Accident Cover is opted.
ii. Coverage of 200% of the opted Sum Insured if such Accidental Death or Permanent Total Disablement occurs while the Insured Person is a fare-paying passenger on a common carrier.
iii. In the event of death or discontinuation of the earning member, Personal Accident coverage would be allowed to continue for non-earning member at the time of Renewal.</td></tr>
</table>

	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 the Policy.
	Health Check Up	Available each policy year (including the first year), to all Adult insured persons who have completed 18 years of Age. • For Sum Insured of ₹5 lacs: Package 1 • For Sum Insured ₹7.5 lacs and ₹10 lacs: Package 2 • For 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 of Sum Insured (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same, 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 Sum Insured for each policy year up to the maximum of 1,000% of Sum Insured irrespective of any claim made in the previous Policy Year.
	Sarathi	If the Insured Person opts for this optional cover, any hospitalization related to Cancer, Heart, Stroke, & Major Organ/ Bone Marrow Transplant arising due to the below listed Pre-existing disease declared and accepted at the time of policy issuance, will be covered after the first 30 days from the policy Inception date. i. Asthma ii. Diabetes iii. Dyslipidemia iv. Obesity v. Hypertension **Note -** This optional cover is available only during the First Policy Year and not available during renewal. Once Opted cannot be opted out in the subsequent renewal.
	Room Rent Modification	The Insured Person 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 Sum Insured, available from day 1 for 1st claim only, in each policy year.

	Deductible	Insured has option to choose either **Option 1 -** Aggregate Deductible of ₹10K, ₹25K , ₹50K, ₹1L, ₹2 L, ₹3L, ₹4L , ₹5L, ₹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** Non-Medical items covered up to the Sum Insured opted under the policy, in case of In-patient Hospitalization or Day Care Treatment or Domically hospitalization. **2. Durable Medical Equipment** Durable Medical Equipment 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)

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/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