Manipal Cigna
Health Insurance

EVERY DETAIL MATTERS TO YOUR HEALTH.

FIND THEM LISTED IN YOUR POLICY TERMS & CONDITIONS BASE COVER

ManipalCigna Global Health Group Policy
Policy Terms and Conditions
Contents

I. Preamble & Operating Clause

This Policy is a contract of insurance between You and Us which is subject to (a) the terms, conditions and exclusions of this Policy and (b) the receipt of Premium against each Benefit of the applicable in full and (c) the Disclosure to information norm (including by way of the Proposal or Information Summary Sheet) in respect of all Insured Persons and (d) the Policy Schedule/ Certificate of Insurance.

II. Definitions

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

Accident — Accident means a sudden, unforeseen and involuntary event caused by external visible and violent means.

Ambulance — Ambulance means a road vehicle operated by a licensed/ authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

Annexure — Annexure means a document attached as a part to this Policy and marked as Annexure.

Annual Renewal Date — Annual Renewal Date means the anniversary of the Inception date each year or any other date which We agree with you in writing.

Any One Illness — 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 treatment was taken.

Area of Cover — Area of Cover means the geographic coverage area as defined under the Policy and as particularly specified for the Insured Person in the Policy Schedule/ Certificate of Insurance.

AYUSH Treatment — AYUSH Treatment refers to the medical and /or Hospitalization Treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems provided the treatment has been undergone in (in India):
i) Teaching hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
ii) AYUSH Hospitals having registration with a Government authority under appropriate Act in the state/ UT and complies with the following as minimum criteria:
a. Has at least fifteen in-patient beds
b. Has minimum five qualified and registered AYUSH doctors
c. Has qualified paramedical staff under its employment round the clock
d. Has dedicated AYUSH therapy sections;
e. Maintains daily record of patients and makes these accessible to the insurance company's authorized personnel.

Benefit — Benefit means any benefit under the Policy, as opted and available for the Insured Person and specified in the list of benefits in the Policy Schedule/ Certificate of Insurance.

Cancer of specific severity — A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma. The following are excluded:

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

Cashless facility

Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

Certificate of Insurance/ Policy Certificate

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

Complementary treatment

Complementary treatment means:

- Physiotherapy: Treatment of an Illness, Injury or deformity through physical methods such as massage, heat treatment, etc.
- Acupressure: The application of pressure (as with the thumbs or fingertips) to the same discrete points on the body stimulated in acupuncture that is used for its therapeutic effects (such as the relief of tension or pain).
- Acupuncture: Acupuncture is a form of alternative medicine in which thin needles are inserted into the body for treatment of various physical and mental conditions.
- Chiropody: A specialty supplementary to medicine devoted to the care of the feet and the treatment of minor foot complaints such as ingrowing toenails, bunions, plantar warts, foot strain, flat feet and the care of the feet of diabetics.
- Chiropractic: A system that, in theory, uses the recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body, particularly of the spinal column and the nervous system, in the restoration and maintenance of health.
- Osteopathy: A system of medicine based on the theory that disturbances in the musculoskeletal system affect other bodily parts, causing many disorders that can be corrected by various manipulative techniques in conjunction with conventional medical, surgical, pharmacological and other therapeutic procedures.
- Homeopathy: A system of complementary medicine in which ailments are treated by minute doses of natural substances that in larger amounts would produce symptoms of the ailment.
- Ayurveda: A science of life based on the Vedas, the Hindu books of knowledge and wisdom. It is the traditional Hindu system of medicine (incorporated in Vedas), which provides an integrated approach for prevention and treatment of illness trough lifestyle interventions and natural therapies.

Condition Precedent

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

Congenital Anomaly

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

Contribution

Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured Person to share the cost of an indemnity claim on a ratable proportion of the Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis. This clause shall not apply to any Benefit offered on fixed benefit basis.

Co-pay/ Co-Payment

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

Cosmetic Surgery

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

Critical Illness

Critical Illness shall mean Illnesses listed below or as customized for a Policy and specified under the Policy Schedule/ Certificate of Insurance.

- Cancer of specific severity
- Myocardial Infarction (First Heart Attack - of Specific Severity)
- Open Chest CABG
- Open Heart Replacement or Repair of Heart Valves
- Coma of Specified Severity
- Kidney Failure Requiring Regular Dialysis
- Stroke Resulting in Permanent Symptoms
- Major Organ/ Bone Marrow Transplant
- Permanent Paralysis of Limbs
- Motor Neurone Disease with Permanent Symptoms
- Multiple Sclerosis with Persisting Symptoms
- Primary Pulmonary Hypertension
- Aorta Graft Surgery
- Deafness (Loss of Hearing)
- Blindness (Loss of Sight)
- Aplastic Anaemia
- Coronary Artery Disease
- End Stage Lung Disease
- End Stage Liver Failure
- Third Degree Burns (Major Burns)
- Fulminant Hepatitis
- Alzheimer's Disease
- Bacterial Meningitis
- Benign Brain Tumour
- Apallic Syndrome
- Parkinson's Disease
- Medullary Cystic Disease
- Muscular Dystrophy
- Loss of Speech
- Systemic Lupus Erythematous
- Loss of Limbs
- Major Head Trauma
- Brain Surgery
- Cardiomyopathy
- Creutzfeldt-Jacob Disease (CJD)
- Terminal Illness

Day Care Centre

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:-

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

In respect of US based admissions, this also includes Surgical Procedures carried out in the Medical Practitioner's surgery.

Day Care Treatment

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

i. i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. ii. which would have otherwise required a hospitalization of more than 24 hours.

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

Deductible

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

Dental Treatment

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

Dentist

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

Dependent

Dependent means the member's spouse or unmarried, civil/ contractual partner or child or parent who has been enrolled in the Policy.

Dependent Child

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

Eligible Female

Eligible Female is a person who is a female member or a female Spouse or unmarried, civil/contractual partner of a member.

Emergency

Emergency shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

Emergency Care

Emergency Care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Employee

Employee means any member of Your staff who is proposed and sponsored by You who becomes an Insured Person.

Exclusions

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

Grace Period

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

HDU

HDU means the High Dependency Unit,an area in a Hospital, usually located closely to the ICU where patients can be cared for more extensively than a normal ward but not to the point of intensive care.

Hospital (India)

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 enactments specified under the Schedule of Section 56 (1) of the said act Or complies with all minimum criteria as under:
- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds, in towns having a opulation of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

Note: For the purpose of this Policy, a Hospital situated outside India shall refer to any equivalent institution organisation established for in- patient care and day care and treatment of Injury or Illness and which has been registered or licensed as a medical or surgical hospital or clinic as per the applicable law, rules and/or regulations in the country in which it is located and where the patient is under the care or supervision of a Medical Practitioner or Qualified Nurse and does not include a nursing home.

Hospitalization

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

Illness

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

a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    2. it needs ongoing or long-term control or relief of symptoms
    3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    4. it continues indefinitely
    5. it recurs or is likely to recur

Inception Date

Inception Date means the inception date of this Policy as specified in the Policy Schedule when the coverage under the Policy becomes effective for the Insured Persons and their dependents (if any).

Injury

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.

In-patient

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

In-patient Care

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.

Insured Person

Insured Person means the member or Dependents named in the Policy Schedule, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate Premium paid.

Intensive Care Unit (ICU)

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.

Maternity Expense

Maternity Expense means:
- medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- Expenses towards lawful medical termination of pregnancy during the policy period.

Medical Advice

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

Medical Assistance Service

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

Medical Expenses

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.

Medical Practitioner

A Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or appropriate authority of the country where Insured Person is availing treatment outside India/ Country of origin and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Medically Necessary

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

Minor Surgical Procedures and Associated Treatments	Minor Surgical Procedures and Associated Treatments are any surgical Treatments or Surgical Procedures that do not require a general anaesthetic or overnight Hospital stay, e.g. surgical treatment of an ingrown toe nail.
Network Provider	Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
New Born Baby	Newborn baby means baby born during the Policy Period and is aged upto 90 days.
Nominee	Nominee means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.
Non-Network	Non-Network Provider means any hospital, day care centre or other provider that is not part of the network.
OPD treatment	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.
Operation	Operation means any procedure described as an operation in the schedule of Surgical Procedures.
Out-Patient	Out-Patient means a patient who undergoes OPD treatment.
Policy	Policy comprises of Policy wordings, Certificates of Insurance issued to the Insured Persons, group Proposal Form/ Enrolment Form and Policy Schedule 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.
Policy Period	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.
Policy Schedule	Policy Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the available Sum Insured under a Benefit or a set of Benefits, the Policy Period and the Sub-limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
Policy Year	Policy Year means a period of 12 consecutive months within the Policy Period commencing from the Inception Date or any subsequent Policy anniversary.
Portability (Applicable only to India Cover)	Portability (Applicable only to India Cover) means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the Insured Person for pre-existing conditions and time bound exclusions if the Policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer.
Pre-Existing Disease	Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or was diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
Premium	Premium shall have to be paid in Indian Rupees and made in favour of ManipalCigna Health Insurance Company Ltd.
Private Room	Private Room means a single occupancy accommodation in a private hospital.
Qualified Nurse	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; or is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided when outside of India.
Reasonable and Customary Charges	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.
Renewal	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.
Room Rent	Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
Service Partner	Service Partner is an assistance company utilised by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services. In India such services will be provided by a TPA.
Specialist	Specialist is a Medical Practitioner who: -- Has received advanced specialist training -- Practices a particular branch of medicine or surgery -- Holds or has held a consultant appointment in a Hospital or an appointment which We accepts as being of equivalent status. -- A physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided is only a specialist for the purpose of physiotherapy as described in the list of Benefits.
Spouse	Spouse means the member's legal husband or wife accepted for cover under the Policy.
Sub Limit	Sub Limit defines limitation on the amount of coverage available to cover a specific type of claim. A sublimit is part of, rather than in addition to, the limit that would otherwise apply to the admissible claim amount.
Sum Insured	Sum Insured means, subject to the terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).
Surgery or Surgical Procedure	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.
Surgical appliance and/or Medical Appliance:	Surgical appliance and/or Medical Appliance: -- An artificial limb, prosthesis or device which is required for the purpose of or in connection with surgery -- An artificial device or prosthesis which is a necessary part of the treatment immediately following Surgery for as long as required by medical necessity. -- A prosthesis or appliance which is medically necessary and is part of the recuperation process on a short-term basis.'
TPA	TPA means any person who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulations 2016 by the IRDAI and is engaged for a fee or remuneration by Us for the purposes of providing health services.
Unproven/ Experimental Treatment	Unproven/Experimental Treatment means treatment, including drug experimental therapy, which is not based on established medical practice, in India or in country specified in the Policy Schedule, is treatment experimental or unproven.
We/Our/Us	We/Ours/Us means the ManipalCigna Health Insurance Company Limited.
You/Your/Policyholder	You/Your/Policyholder - the person named in the Policy Schedule/ Certificate Of Insurance who has concluded this Policy with Us.

III. Benefits under the Policy

The Certificate of Insurance will specify which Benefits are in force for the Insured Person during the Period of Insurance. Claims made under any applicable Benefit, for the Period of Insurance will be subject to the terms, conditions and exclusions of this Policy, the availability of the Sum Insured for that Benefit, any applicable Sub-Limits and subject always to the availability of the aggregate limit of the Policy (if applicable and specified in the Policy Schedule/Certificate of Insurance). Claims will be payable in excess of the applicable Deductible specified in the Policy Schedule/ Certificate of Insurance, if any. Where an event qualifies for an indemnity under more than one Benefit with respect to the same risk/ insured event the Insured Person will be eligible for reimbursement under any one of the Benefits.

All claims paid under the Policy will impact the Sum Insured available under the Policy for that Benefit or set of Benefits. All claims on a Cashless Facility basis must be made in accordance with the procedure set out in Section VII. 4, and all reimbursement claims must be made in accordance with the procedure set out in Section VII. 5, unless specified otherwise.

A claim is payable subject to occurrence of a covered event during the Policy Period unless specified otherwise.

A. Base Covers

BASE 1 (Mandatory)

1. In-patient Hospitalization and Day Care

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment at a Hospital, for more than 24 consecutive hours/ Day Care, arising from an injury due to an Accident or an Illness contracted during the Policy Period, up to the Sum Insured specified under the Policy Schedule/ Certificate of Insurance:

i. Room charges up to:

- Any Hospital Room except suite and above for Hospitalization in India and
- Any Hospital Room up to Private Room for Hospitalization outside India,

ii. Charges for accommodation in ICU/CCU/HDU,
iii. Hospitalization charges,
iv. Operation theatre cost,
v. Surgical Procedures,
vi. Minor Surgical Procedures,
vii. Day Care Treatment,
viii. AYUSH Treatment for In-patient Hospitalization (In India Only),
ix. Medical Practitioner fees,
x. Specialist fee,
xi. Surgeon's fee,
xii. Anaesthetist fee,
xiii. Radiologist fee,
xiv. Pathologist fee,
xv. Assistant Surgeon fee,
xvi. Qualified Nurses fee,
xvii. Medication,
xviii. Cost of diagnostic tests as an In-patient such as but not limited to radiology, pathology tests, X-rays, MRI and CT scans, physiotherapy and drugs, consumables, blood, oxygen.
xix. Surgical appliance and/or Medical Appliance.

If the Insured Person is admitted in a room category or in a room where the Room Rent is higher than the one that is specified in the Policy then the Insured Person shall bear the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.

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

2. Private Ambulance

We will pay the Reasonable and Customary Charges for costs incurred towards shifting an Insured Person to the Hospital for admission in the Emergency ward or ICU or for shifting the Insured Person from one Hospital to another Hospital for better medical facilities by way of road transport unless otherwise specified under the Policy.

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

BASE 2

3. Out-Patient Expenses

We will pay the Reasonable and Customary Charges for the following Out-Patient expenses, in respect of an Insured Person, arising from an injury due to an Accident or an Illness contracted during the Policy Period, if opted and specified under the Policy Schedule/ Certificate of Insurance.

i. Consultations with Medical Practitioners and Specialists;
ii. Prescribed medicines, drugs and dressings; expenses towards over the counter (OTC) medicines shall be payable if opted and specified under the Policy Schedule/ Certificate of Insurance.
iii. Diagnostic tests such as laboratory tests, radiology and pathology, MRI, CAT scan, PET scan.

The cover is available:

i. only if cover Base 1 is opted under the Policy.
ii. up to Sum Insured/ limit specified under the Policy Schedule/ Certificate of Insurance.

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

IV. Co-pay and Deductible

1. Co-pay

The Co-pay will apply to all indemnity claims made under the Base Covers as well as Optional Covers available under the Policy. If the Co-pay is in force, We will be liable to pay only the difference percentage of the admissible claim amount that We assess for the payment in respect of the Policy and the balance opted Co-pay percentage shall be borne by the Insured Person.

The Policy Schedule/ Certificate of Insurance will specify the applicable Co-pay under Base and/ or Optional Covers.

Wherever Co-pay is opted under any Optional Cover, the opted percentage of Co-pay shall be applicable for the Optional Cover and the Co-pay opted under the Base Cover shall not be applicable for such Cover.

2. Deductible

The Deductible will apply to all indemnity claims, made under Base as well as Optional Covers. If the Deductible is in force, We will be liable to pay only the difference amount of the admissible claim amount that We assess for the payment in respect of the Policy and the balance opted Deductible amount shall be borne by the Insured Person.

The Policy Schedule/ Certificate of Insurance will specify the applicable Deductible under Base and/ or Optional Covers.

Wherever Deductible is opted under any Optional Cover, the opted amount of Deductible shall be applicable for the Optional Cover and the Deductible opted under the Base shall not be applicable for such Cover.

There are Optional covers available with the Policy. Refer Policy Terms & Conditions - Optional Covers annexed herewith for Optional Covers.

V. Waiting Period & Permanent Exclusions

A. Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person since the Inception Date of the first Policy or coverage for the Insured Person **and claims shall be assessed accordingly.**

1. Pre-existing Diseases Waiting Period

A Waiting Period specified in the Policy Schedule or Certificate of Insurance shall apply to all Pre-Existing Diseases/ Illness / Injury / conditions for each Insured Person.

2. Initial Waiting Period for Hospitalization

A Waiting Period specified in the Policy Schedule/ Certificate of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness/ Injury by the Insured Person other than any Hospitalization due to Accident.

3. Specific Illness Waiting period

A Waiting Period specified in the Policy Schedule/ Certificate of Insurance shall apply to any treatments, of the following, whether medical or surgical for all Medical Expenses along with their complications on treatment towards:

a) Cataract,
b) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Oestoarthritis and Osteoposrosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertibral discs(other than caused by Accident), all Vertibrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal,
d) Varicose Veins and Varicose Ulcers,
e) Stones in the urinary uro-genital and biliary systems including calculus diseases,
f) Benign Prostate Hypertrophy, all types of Hydrocele,
g) Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region.
h) Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
i) Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/ skin tumors, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,
j) Any Surgery of the genito-urinary system unless necessitated by malignancy.

B. Exclusions

1. Permanent Exclusions

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless otherwise covered or specified under the Policy or any Cover opted under the Policy:

1. Any treatment that arises from attempted suicide or any Injury or Illness that the Insured Person inflicts upon self unless explicitly specified under the Policy Schedule/ Certificate of Insurance and up to the specified limit.
2. Treatment for or in connection with speech and/or occupational therapy unless it:
   - is recommended by a specialist/ Medical Practitioner,
   - it has likelihood of being restored,
   - is intended to restore skills which previously existed and have been lost as a result of an acute medical condition and
   - is specified under the Policy Schedule/ Certificate of Insurance
3. Dental Treatment or orthodontic treatment unless specified under the Policy Schedule/ Certificate of Insurance, for the Insured Person.
4. Any alternative treatments or treatments in nature cure clinics, health spas and nursing homes.
5. Charges for residential stays in Hospitals which are arranged wholly or partly for domestic reasons or where treatment is not required or where the Hospital has effectively become the place of domicile or permanent abode.
6. Any treatment directly related to surrogacy. We will not pay for expenses arising in respect of an Insured Person who acts as a surrogate or anyone else acting as a surrogate for an Insured Person.
7. Birth control procedures, contraceptive supplies or services, including complications arising thereof.
8. Any treatment needed because of or relating to Sterility, impotency, venereal disease, cost of vasectomy, including complications arising thereof.
9. Expenses towards hormone replacement therapy, surrogate or vicarious pregnancy, including complications arising thereof.
10. Expenses towards voluntary termination of pregnancy including complications arising thereof
11. Any treatment needed because of or relating to fertility, infertility including IVF and other assisted conception procedures, subfertility, including complications arising thereof.
12. For claims outside of India, Supportive treatment for chronic kidney failure or kidney failure which cannot be cured. Treatment for kidney dialysis will be covered if such treatment is available in the location of assignment or if not available, treatment will be covered in the patient's country of domicile or centre of excellence nearest the location of assignment. Only treatment costs

for kidney dialysis will be covered; travel and accommodation expenses in connection with such treatment will not be covered.

13. Any treatment to change the refraction of one or both eyes, including refractive keratotomy (RK) and photorefractive keratectomy (PRK).
14. Injury or disability directly or indirectly caused or contributed to whilst engaging in or taking part in war, warlike operations (whether war be declared or not or while carrying out army, naval or air services operations of any country), civil war, invasion, terrorist activities, rebellion, act of foreign enemies, hostilities, public defense, rebellion, revolution, insurrection, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority.
15. Injury caused whilst flying or taking part in aerial activities (including cabin) except as an auhtorised passenger in a regular scheduled airline or air charter company.
16. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.
17. Any form of non-emergency travel costs in respect of an Emergency Evacuation or Repatriation specifically payable under International Emergency Services, which is not specified in the Policy Schedule/ Certificate of Insurance or not intimated and approved in advance by Us.
18. International services expenses for Emergency Evacuation, Medical Repatriation and transportation costs payable to any Service Partner where the treatment needed is not covered under the Plan.
19. International services expenses related to Medical Repatriation and Evacuation for:

- non-Emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or sickness; or
- a condition which would allow for treatment at a future date convenient to the Insured Person and which does not require emergency evacuation or repatriation; or
- medical care or services scheduled for the patient's or provider's conveniences which are not considered an Emergency

20. Any expenses for ship-to-shore evacuations.
21. Sex change operations or any treatment needed to prepare for or recover from these operations (for example, psychological counselling) including complications arising out of such treatment. Any treatment/Surgery or preparation for change of sex.
22. Any cosmetic or plastic surgery or cosmetic procedure that improves physical appearance, unless it is Medically Necessary for normal functioning of an organ or a body part, arising as a consequence of an Accident or Cancer or burns or specific disease of breast which itself would have been covered under the Policy.
23. Any surgical and non-surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control programs or complications thereof.
24. Any treatment that arises from or is any way connected with Injury, sickness or disablement as a result of taking part in a sporting activity on a professional or Semi-Professional basis; or solo scuba-diving or scuba diving at depths below 30 metres unless the diver is PADI qualified (or equivalent) for that depth. Injury caused while engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.
25. Any form of Unproven/Experimental Treatment (or procedure) that does not amount to orthodox treatment.
26. Any treatment for or in connection with developmental disorders namely:

- developmental reading disorders
- developmental arithmetic disorders
- developmental language disorders
- developmental articulation disorders
- Other disorder which medically qualify as developmental; disorder

27. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).
28. Expenses relating to:

i. Prostheses which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised.
ii. Corrective devices which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised.
iii. Medical Appliances, which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised.
iv. 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.
v. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.

29. Costs of Routine medical, eye examinations, cost of spectacles, laser Surgery for cosmetic purposes or corrective Surgeries or contact lenses,
30. Costs of Ear examinations, hearing tests
31. Cost of hearing aids or cochlear implants
32. Incidental costs including newspapers, taxi fares, telephone calls, guests' meals and hotel accommodation
33. Costs for treatment that has not yet taken place irrespective of whether advance authorization has been given or a Cashless facility has been put in place.
34. Expenses towards preventive check-ups and treatments, diagnostic services, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and Treatment even if the same requires confinement at a Hospital, wellness treatments and rehabilitation services.
35. Costs for Psychiatric or psychological examinations or treatment.
36. Costs for Non-Surgical & Minor Surgical Procedures & treatment conducted on Out-patient basis.
37. Costs associated to palliative care or hospice care.
38. Expenses in respect of accompanying person including cost of accommodation.
39. Costs of Nurse visit at home to provide nursing services.
40. Any Illness or Hospitalization arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.
41. Any claim relating to events occurring before the Inception Date or otherwise outside of the Policy Period.
42. Expenses towards Vaccinations, immunizations, inoculations and administration except expenses towards vaccinations for post-bite treatment.
43. Any External Congenital Anomalies or any consequence thereof.
44. Maternity, child birth natal care and any related expenses and any related complications, Medically Necessary termination of pregnancy, including any changes affecting other chronic conditions of the Insured Person as a result of the pregnancy. Pregnancy related counselling, cost of vitamins, supplements, and unrelated tests.
45. Any expenses incurred towards a New Born baby.
46. Vitamins and tonics unless forming part of Treatment for Illness or Injury and prescribed by a Medical Practitioner.
47. Certification / diagnosis / treatment from a person not registered as a Medical Practitioner under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he/she is licensed for, or any diagnosis or treatment that is not scientifically recognised.
48. Expenses towards organ transplantation towards solid organs, bone marrow/ stem cell transplant procedures.
49. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof.
50. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis and any condition directly or indirectly caused by or associated with them.
51. Medical Expenses incurred towards the Insured Person when he/ she is outside the Area of Cover specified under the Policy Schedule/ Certificate of Insurance.
52. Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells.
53. Any robotic, remote Surgery or Treatment using cyber knife.
54. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
55. Any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products.
56. Issue of medical certificates and examinations as to suitability for employment or travel.
57. Artificial life maintenance, including life support machine use, where such Treatment will not result in recovery or restoration of the previous state of health.
58. Treatment for general debility, ageing, convalescence, sanatorium Treatment, rehabilitation measures, private duty nursing, respite care, run down condition or rest cure.
59. Ailment requiring Treatment due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and Treatment for de-addiction, or rehabilitation.
60. Any Treatment received in convalescent homes, convalescent Hospitals, health hydros, nature cure clinics or similar establishments.
61. For complete list of Non-medical expenses, refer Annexure II "Non-Medical Expenses" to the Policy.

VI. Area of Cover

The Policy provides the following options for the applicable Area/s of Cover. The Policy Schedule/ Certificate of Insurance will specify the Area of Cover option that

is in force for the group. We will indemnify the Medical Expenses incurred in the applicable Area of Cover for the listed Benefits in respect of the Insured Person.

1. South Asia (Indian Sub-continent), Asian Middle East, African countries
2. Asia Pacific excluding Hong Kong, Singapore
3. Asia Pacific including Hong Kong, Singapore
4. India, Europe, Canada, Latin America and Caribbean island countries
5. Worldwide excluding United States
6. Worldwide including United States

For a specific group, the Area of Cover may be limited to any particular country or region which is a part of any one or a part of combination of above list of Area of Covers.

VII. Claims procedure

1. Condition Precedent

The fulfilment of the terms and conditions of this Policy (including the realisation of Premium by their respective due dates) in so far as they relate to anything to be done or complied by You/Insured Person, including complying with the following steps, shall be the Condition Precedent to the admissibility of a claim.

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

Processing of claims for Cashless facility and/or for reimbursement and providing access to the Network Provider will be through Our Service Partners. Details of the Service Partners will be available on the health card issued by Us to the Insured Persons as well as on Our website. The Service Partners provide access to domestic as well as global Network Providers and will facilitate claims for Cashless Facilities. The Service Partner may also support Us in assessing of reimbursement claims. In India the claims will be serviced by an approved Third Party Administrator (TPA) while all Claims outside of India will be managed by a wholly owned non-insurance Cigna Corporation subsidiary that provides international medical assistance services.

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

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

The updated applicable list of Network Providers is available on Our website. Details of applicable Network Providers may also be obtained from Our call centre or contacting Our Service Partner. In advance of availing Cashless facilities from a Network Provider, the updated list may be checked to ensure that the Network Provider can provide a Cashless facility in respect of the treatment required for the Insured Person.

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

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

(b) Follow the directions advice or guidance provided by a Medical Practitioner.

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

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

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

Claim Process

3. Claim Intimation

Upon the discovery or occurrence of an Illness /Injury or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee as the case may be must notify Us/ Our TPA/ Our Service Partner either in writing or at the call centre and shall undertake the following:

In the case of Planned Hospitalization - The Insured Person will intimate such admission at least 3 days prior to the planned date of admission.

In the case of Emergency Hospitalization - The Insured Person will intimate such admission within 48 hours of such admission but not later than discharge from the Hospital.

The following details are to be provided to Us/ Our TPA/ Our Service Partner at the time of intimation of Claim:

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

4. Cashless Process

Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider for Illness/ Injury or any other contingency that is covered under the Policy.

For all Cashless Facility pre-authorizations, Insured Person will, in any event, be required to settle all non-admissible expenses, expenses towards sub-limit, Co-Payment and / or Deductibles (if applicable), directly with the Hospital/ Network Provider.

Conditions -

- Cashless facility is available only at Our Network Providers.
- For availing Cashless facility, the Insured Person must present the health card as provided by Us, along with a valid photo identification proof Member ID/ Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by Us).

i. For Planned Hospitalization:

a. The Insured Person should approach the Network provider at least 3 days prior to the admission for Hospitalization.

b. The Network Provider will issue the request for authorization letter.

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

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

e. If the information provided in the request is sufficient to ascertain the authorization We shall issue the authorization Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorization will be issued. All authorizations will be issued within a **period of 6 hours** from the receipt of last complete documents.

f. The Authorization letter will include details of Amount Sanctioned, any specific limitation on the claim, any applicable sub-limits, Co-pays or Deductibles and non-payable items if applicable.

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

ii. In case of Emergency Hospitalization

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

b. The Network Provider shall forward the request for authorization within 48 hours of admission to the Hospital as per the process under VII.4 i. but not later than actual discharge from the Hospital.

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

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

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

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 VII.4 i. including details of the specific circumstances which have led to the need for increase in the previously authorized limit.

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

iii. We shall accept or decline such additional expenses within 24 (twenty-four) hours of receiving the request for enhancement from Network Provider.

In the event of a change in the treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described at Section VII.4 i. above.

At the time of discharge:

The Network Provider may forward a final request for authorization for any residual amount to Us along with the Insured Person's discharge summary and the billing format in accordance with the process described at Section VII.4 i. above.

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

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

Submission of Claim Documents:

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

a. Claim Form Duly Filled and Signed
b. Original pre-authorization request
c. Copy of pre-authorization approval letter (s)
d. Copy of Photo ID of Patient Verified by the Hospital
e. Original copy of consultations

f. Original discharge/death summary;

g. Operation theatre notes(if any);

h. Original Hospital main bill and break-up of the bill;

i. Original investigation reports, X Ray, MRI, CT Films and HPE;

j. Medical Practitioner's reference slips for investigations/pharmacy;

k. Original pharmacy bills, prescriptions, and invoices;

l. MLC/FIR report/post mortem report (if conducted).

m. Bills from registered service provider (Ambulance Cover)

The Documents listed above will apply for claims in India, however for claims arising due to Hospitalization of the Insured Person outside of India the requirements may vary based on the applicable agreements between the Service Partner and the Network Provider and any applicable provisions of local laws, regulations or rules.

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

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

We, at Our sole discretion, reserve the right to modify, add or restrict any Network Provider for Cashless facilities available under the Policy. Before availing the Cashless facility, You / Insured Person is required to check the applicable/latest list of Network Provider on the Company's website or by calling Our call centre.

5. Claim Reimbursement Process

a. Collection of Claim Documents

Wherever Insured Person has opted for a reimbursement of expenses, he/she may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense not later than 90 days from the date of discharge from the Hospital. The Insured Person can obtain a claim form from any of Our branch offices or download a copy from Our website www.manipalcigna.com

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

We may call for any additional documents/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarityOur branch offices shall give due acknowledgement of collected documents to the Insured Person.

b. If the submission of claim documents as specified in Section VII.5 a. above is delayed, then in addition to the documents mentioned above, reasons for such delay shall also be provided to Us in writing. We will condone delay on merit for delayed claims where the delay has been proved to be for reasons beyond Insured Person's control.

Documents listed above will apply for claims in India, however for claims outside of India, the requirements may be subject to variation based on Our existing agreements, local market practice and provisions of applicable law.

6. Scrutiny of Claim Documents

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

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

c. We will send a maximum of 3 (three) reminders following which We will send a closure letter.

d. We shall settle the claim payable amount arrived post scrutinizing the claim documents excluding the deficiency intimated to You.

e. In case a reimbursement claim is received when a pre-authorization letter has been issued for the same claim, before approving such claim a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the all the dues in respect of the Insured Person have been settled with the Network Provider. Once such check and declaration is received from the Network Provider, the claim will be processed.

7. Claim Assessment

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

i. If the provisions of the Contribution Clause apply, under Section VIII.22, Our liability to make payment under the claim shall be first apportioned accordingly.

ii. Where a room accommodation is opted for higher than the eligible room category under the plan, only the Room Rent for the applicable accommodation will be apportioned.

iii. Subsequent to applying Section VII.7 (i) and (ii) to the admissible claim amount, the following cost sharing mechanisms will be applied sequentially if applicable -

iv. Deductible or Co-pay (if applicable)

v. At any given stage if the Insured Person's total cost sharing amount under Deductible, Co-pay (if applicable) under Section VII.7 (iii) above is equal to the opted 'Maximum limit on Out of Pocket' limit, no further deductions will apply subject to the Sum Insured available for specific Benefits (if applicable) and in any case not greater than the Sum Insured available under the Plan.

Claim Assessment for Benefit Plans:

We will pay fixed benefit amounts where available under the Base Benefits and the Optional Benefits as specified in the Policy Schedule/ Certificate in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts other than the ones specified in the Policy.

8. Re-opening of Claim

We may allow a closed claim to be reopened depending on the validity and the circumstances of the claim.

9. Claims Investigation

We may investigate claims at Our own discretion to determine validity of a claim. Such investigation shall be concluded within 15 days from the date of assigning the claim for investigation and not later than 30 days from the date of receipt of last necessary document. Verification carried out, if any, will be done by individuals or entities authorized by Us to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by Us.

10. Settlement & Repudiation of a claim

We shall settle or reject the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of the IRDAI (Protection of Policyholders' interests) Regulations 2017 and the IRDAI (Health Insurance) Regulations, 2016.

In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate (in India).

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

In case of delay beyond stipulated 45 days We shall be liable to pay interest at a rate 2% above the bank rate (in India) from the date of receipt of last necessary document to the date of payment of claim

11. Representation against Rejection

Where a rejection is communicated by Us, the Insured Person may, if so desired within 15 days from the date of receipt of the claims decision represent to Us for reconsideration of the decision.

12. Claims falling in 2 policy periods

If a Hospitalization claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles & Co-pays for each Policy Period subject to limit of Sum Insured provided that You have renewed the Policy with Us for the subsequent year.

13. Payment Terms

a. The Sum Insured opted by the Insured Person 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.

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

c. For Cashless Claims, the payment shall be made to the Network Provider where discharge shall be treated as full and final discharge of Our liability under the Policy.

d. For Reimbursement Claims, the payment will be made to You/ the Insured Person. In the unfortunate event of an Insured Persons death, We will pay the Nominee (as named in the Policy Schedule) and in case of no Nominee to the legal heir who holds a succession certificate or Indemnity Bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

14. Wellness, Dental & Vision Benefit Claim

The Insured Person shall avail these Benefits as defined in 'Policy Terms and Conditions for Optional Covers', under Section I. 23, 24 & 25, if opted for.

a) Submission of claim

Insured Person can send the Wellness Benefit claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to Our branch office or head office.

b) Assessment of Claim Documents

We shall assess the claim documents and ascertain the admissibility of claim.

c) Settlement & Repudiation of a claim

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

d) In respect of orthodontic claims for children below 18 years, pre-authorization is a must.

For Claims in respect of orthodontic treatment towards dependent children below 18 years of Age, the member or dependent must send the following information prepared by the dentist who is to carry out the proposed treatment to Us before treatment starts, so that We can confirm the Benefit that will be payable.

- a full description of the proposed treatment;
- X-rays and study models;
- an estimate of the cost of the treatment.

Payments under this Benefit will be payable only if We have authorised such payment before the respective treatment commences.

15. Emergency evacuation & Medical repatriation –

a) In the event of an Insured Person requiring Emergency evacuation and medical repatriation, Insured Person, must notify Us immediately either at Our call centre or in writing.

b) Emergency medical evacuations shall be pre-authorized by Us

c) Our team of Specialists in association with the Service Provider shall determine the Medical Necessity of such Emergency evacuation or medical repatriation post which the same will be approved.

16. Health Appliances Cover

In an event of an Insured Person being prescribed a health appliance for medical purpose by a Medical Practitioner, he/she can send the claim request along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by You/ Insured Person as the case may be, to Our branch office or head office at Your own expense. We may call for any additional documents/information as required based on the circumstances of the claim.

All claims under this Benefit will be payable only if it is pre-authorised by Us

17. Deductible

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

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

b. Wherever such Hospitalization claims as stated under Section VII.4. (i) above is being covered under another Policy held by You, We will assess the claim on available photocopies duly attested by Your Insurer / TPA as the case may be.

VIII. Terms and conditions

1. Duty of Disclosure - Disclosure to information norm

The Policy shall be null and void and We shall have no liability to make payment of any claims under any Benefits under this Policy in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the group proposal form, personal statements, declarations, medical history and connected documents, or any material information having been withheld or a claim being fraudulent or any fraudulent` means or device being used by You/ Insured Person/ Dependent or any one acting on their behalf, under this Policy. Under such circumstance We may at Our sole discretion cancel the Policy and the Premium paid shall be forfeited to Us.

2. Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of Premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by You or any of the Insured Persons, shall be the Condition Precedent to Our liability under this Policy.

3. Maintenance of Records:

The Insured Person shall maintain all records and books of accounts reasonably required in an accurate manner.

4. Alterations in the Policy

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

5. Material Information for administration

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

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

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

6. Eligibility

The Policy provides cover on an individual basis where each member has a separate Sum Insured. To be eligible for coverage under the plan, the Insured Person must be-

- A group member/ Employee of the Policyholder or non-employer group enrolled member where the group pertains to members/ Employees of a Group/ Company.
- The minimum Age of entry for a member and Dependent spouse or unmarried, civil/contractual partner, parent, for entering into this policy is 18 years and the maximum Age of entry is 95 years. Dependent Children can be covered from day 1 of birth up to 25 years of Age.
- Renewals will be available for lifetime provided the Insured Person is still employed with/ member of the Group and nominated for coverage.
- New Born Baby will be accepted for cover (subject to the limitations of the new born benefit) from birth. Acceptance of New Born Baby as Insured Persons is subject to written notification within 30 days of birth and receipt of the agreed Premium within a further 30 days following notification.

It is clarified that for the purpose of availing this Policy, the Master Policyholder/ You shall ensure that the minimum number of Employees/members who will form a group under this Policy shall be 7 or as prescribed by the IRDAI form time to time.

This Policy shall be applicable in the Area/s of Cover specified in the Policy Schedule/ Certificate of Insurance.

7. Insured Person

Only those persons named as an Insured Person in the Policy Schedule/ Certificate of Insurance shall be covered under this Policy. Any person may be added as an Insured Person during the Policy Period after his application has been accepted by Us, additional Premium to be paid and We have issued an endorsement confirming the addition of such person as an Insured Person under this Policy.

8. Loading and/or exclusion

On change of the Insured Person's risk profile or the parameters on which Premium is derived the coverage under this Policy may cease, unless specifically agreed by Us. However, in such cases, We may underwrite the case in line with the underwriting policy of the product.

9. Operation of Policy & Certificate of Insurance

The Policy shall be issued for the duration as specified in the Policy Schedule/ Certificate Of Insurance. The Policy takes effect on the Inception Date stated in the Policy Schedule and/or the Certificate of Insurance and ends on the date of expiry of the Policy. For specific groups, upon request, all additions thereto by way of Certificate/s of Insurance shall be valid up to the Policy Period commencing from the actual date of addition to the Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

10. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/ the Insured Person in possession of any official of Ours shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve the Insured Persons from their duty of disclosure, irrespective of acceptance of Premium by the Us.

11. Geography

The geographical scope of this Policy applies to events limited to the Area/s of Cover opted and which are specified in the Policy Schedule/ Certificate of Insurance.

12. Dispute Resolution & Applicable Law

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

13. Premium

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

Premium will be subject to revision at the time of Renewal of the Policy and as approved by the IRDAI. Further, the Premium shall be paid in Indian Rupees and in favour of ManipalCigna Health Insurance Company Ltd.

14. Free Look period

A period of 15 days from the date of receipt of the Policy document, and a period of 30 days in case of electronic policies and policies obtained through distance mode, is available to review the terms and conditions of this Policy and to return if the same is not acceptable. The Group Policyholder has the option of cancelling the Policy stating the reasons for cancellation. If there are no claims reported (paid/outstanding) under the Policy then We shall refund the Premium after deducting the risk Premium on pro-rata basis and after retaining the 50% of costs for any medical tests if conducted and the stamp duty charges. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

Free look Period shall not be available on Renewal of this Policy.

15. Parties to the Contract

The only parties to this contract are You and Us.

16. Currency

The monetary limits applicable to this Policy will be expressed in the same currency specified in the Policy Schedule/ Certificate of Insurance. Claims paid in a local currency will be converted at the spot exchange rate on the date of payment of expenses.

17. Addition and Deletion of a Member

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

Additions

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

Deletions

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

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

All addition and deletions that lead to either additional Premium being applied will be generated at the time of addition of such employees/ members and/or Dependents and the same will be paid before the actual start date of the cover in respect of those employees/ members. In case of refund of Premium being generated on the policy due to deletions the same will be refunded or adjusted against future Premium instalments due on the policy.

18. Changes to the terms and conditions of the Policy

We can end the Policy or change any of the terms and conditions relating to the Policy subject to IRDAI approval. If the Policy changes because of new laws, We will inform the Policyholder in writing. In all circumstances, We will give the following notice:

- for changes to the list of Benefits, at least 90 days' notice in writing if allowed as per IRDAI;
- for changes to the Policy terms and conditions, or ending the policy, at least 90 days' notice in writing. The change will take place, failing which the Policy will end on the next annual renewal.

You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, fraud, non-disclosure of material fact or for non-co-operation by You/Insured Person without any refund of premium.

19. Multiple Policies

i. In case of multiple policies which provide fixed benefits, on occurrence of the insured event in accordance with the terms and conditions of the Policies, We shall make the claim payments independent of payments received under similar policies.

ii. If two or more policies are taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases where We have issued the chosen Policy, We shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
2. Claims under other Policy/ies may be made irrespective of the exhaustion of Sum Insured in the earlier chosen Policy / policies.
3. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the Hospitalization costs in accordance with the terms and conditions of the chosen policy.

20. Nominee

The Insured Person can, on the Inception Date or at any time before the expiry of the Policy make a nomination for the purpose of payment of claims, in accordance with the provisions of Section 39 of the Insurance Act 1938, as amended from time to time.

Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement to the Policy is made by Us.

21. No Constructive Notice

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

22. Contribution

If at the time when any claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same claim (in whole or in part), then We shall not be liable to pay or contribute more than its rateable proportion of any Claim. This clause does not apply to Benefit sections. Details of applicability towards Contribution are detailed below.

If the Insured Person is covered under two of more policies during the same period from one or more insurers to indemnify treatment costs and the amount of claim is within the Sum Insured limit of any of the policies, the Insured Person will have the right to opt for a full settlement of their claim in terms of any of the policies under which the Insured Person is covered.

Where the amount to be claimed exceeds the Sum Insured under a single policy after considering Deductibles, Co-pays (if applicable), the Insured Person can choose the insurer with which they would like to settle the claim.

Wherever We receive such claims We will have the right to apply the Contribution clause while settling the claim.

23. Subrogation

You and/or any Insured Person will do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by Us for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which We are/or would become entitled upon Us making any payment of a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither You nor any Insured Person shall prejudice these subrogation rights in any manner and provide Us with whatever assistance or cooperation is required to enforce such rights. Any recovery that We make pursuant to this clause shall first be applied to the amounts paid or payable by Us under this Policy and any costs and expenses incurred by Us for effecting a recovery, whereafter We shall pay any balance remaining to the Insured Person. This Section does not apply to Benefit sections.

24. Grace Period & Renewal

The Policy may be renewed by mutual consent and in such event the Premium payable on Renewal of the Policy 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 or from the date of next instalment due date. We will not be liable to pay for any claim arising out of an Injury/ Accident/ Condition that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act, 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

We shall not be bound to give notice that such Premium on Renewal is due. A Policy shall be ordinarily renewable unless any fraud, moral hazard, misrepresentation or non-cooperation by the Insured Person or on his behalf is found either in obtaining insurance or subsequently in relation thereto.

Where such behaviour has been noticed by an individual employee/ member We will terminate cover for the specific employee/ member and his/her Dependents including further Renewals and the cover for the remaining group members will continue. Where it is found that the Policyholder is involved in such above situations, the complete Policy will be terminated.

Revival Period:

Instalment (less than annual) premium policies may be revived by mutual consent and in such event the Revival premium should be paid to Us within 15 days of the installment due date. Wherever Premiums are not received within the revival period, the Policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the policy. However, We will be liable to pay in respect of all claims where the treatment/admission has commenced before date of termination of such policies.

Renewal Terms

Alterations like increase/ decrease in Sum Insured or Optional Covers, can be requested at the time of Renewal of the Policy. We reserve Our right to carry out assessment of the group and provide the Renewal quote in respect of the revised Policy.

Where We have discontinued or withdrawn this product/plan or where You will not be eligible to renew as You have moved out of the Group, You will have the option to renew under the nearest substitute Policy being issued by Us, provided Benefits payable shall be subject to the terms contained in such other policy which has been approved by the IRDAI.

We may in Our sole discretion, revise the Premiums payable under the Policy or the terms of cover, provided that all such changes are approved by the IRDAI and are in accordance with the IRDAI rules and regulations as applicable from time to time.

25. Cancellation

Request for Cancellation shall be intimated to Us from Your side by giving 15 days' notice in which case We shall refund the Premium for the unexpired Policy Period as per the short period scale mentioned below.

Premium shall be refunded only if no claim has been made under the Policy.

Policy Period : 1 Year	
Policy in force upto	**Premium Refund %**
30 days	75%
90 days	50%
180 days	25%
181 days and more	Nil

For instalment Premium, We will refund Premium on pro-rata basis after deducting Our expenses.

You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, fraud, non-disclosure of material fact or for non-co-operation by You / Insured Person without any refund of Premium.

26. Our Right of Termination

Prior to the termination of the Policy at the expiry of the Policy Period shown in the Policy Schedule, cover will end immediately for all Insured Persons, if:

- if You do not pay the Premiums owed under the Policy within the Grace Period.
- For Non-Indian Nationals returning to their country of domicile member will be eligible for coverage under the applicable Policy for coverage until the end of the Policy or earlier if specifically terminated by the employer.

- there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of Premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- there is non-cooperation by You/ Insured Person, with refund of Premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If treatment has been authorised or a cashless approval has been issued, We will not be held responsible for any treatment costs if the Policy ends or an employee/ member or Dependent leaves group or if the policy is no longer in force, before treatment has taken place. However, We will be liable to pay in respect of all claims where the treatment/admission has commenced before date of termination of such policy.

Termination for Insured Person's cover

a. On Immediate basis

Cover will end for an Employee/ member

- If the Insured Person dies. You may agree to continue cover for his/her Dependents up to the next Annual Renewal Date when their cover under this Benefit will end
- If the Insured Person ceases to be a member of the group.
- If We stop receiving Premiums for Insured Person and his/ her Dependents (if any).
- When this Policy terminates at the expiry of the Policy Period shown in the Policy Schedule.

Cover will end for a Dependent

- If he or she dies.
- When he or she ceases to be a Dependent;
- If the Insured Person ceases to be a member of the group.

b. At the next Annual Renewal Date

Cover will end for spouse or any unmarried partners

- If an employee/ member gets divorced or the unmarried partners no longer live together or a civil/ contractual partnership is dissolved, then the spouse or unmarried, civil/contractual partner will no longer be considered as a Dependent for the purposes of this Policy.

Cover will end for the spouse or unmarried, civil/contractual partner

- Cover for the spouse or unmarried, civil/contractual partner ends as soon as the final decree/final dissolution order has been granted.

27. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

The special provision shall be within the purview of the Policy Terms and Conditions.

28. Fraudulent Claims

If any claim is found to be 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 You or the Insured Person or anyone acting on their behalf to obtain any Benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons covered as per allowed relationships or as dependents.

We will have the right to reclaim all amounts and Benefits paid in respect of a claim which is fraudulent as mentioned above under this condition as well as under the condition for "Disclosure to information norm" under this Policy.

29. 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.

30. Portability

Upon the Insured Person ceasing to be an Employee/member of the group policyholder, such Insured Person shall have the option to migrate to an approved retail health insurance policy available with Us, provided that:

a. We have discontinued or withdrawn this product or the Insured Person will not be eligible to renew as he/she ceases to be a member of the group, such Insured Person will have the option to migrate to the nearest substitute policy being issued by Us with continuity of Benefits and in accordance with the Portability guidelines issued by the IRDAI (to the extent applicable).

b. Continuity of Benefits will be provided for the period based on the number of years of continuous coverage under this Policy with Us.

c. The application for Portability should have been received by Us at least 45 days before ceasing to be a member of the group/Employee of the Policyholder.

d. For porting to another health insurance policy available with Us, We may subject such proposal to Our medical underwriting and decide the terms and conditions upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.

e. Subject to the decision of Our underwriting team, We will decide the terms and conditions upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.

f. Subject to board approved Underwriting Policy.

g. After maintaining the Policy with Us, the Insured Person may port the policy to any other retail product offered in the market in accordance with applicable law.

31. Endorsements

The Policy will allow the following endorsements during the Policy Year. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later other than for change in date of birth or gender which will be with effect from the Inception Date.

a) **Non-Financial Endorsements – which do not affect the premium.**
Rectification in name of the proposer/ policyholder / Insured Person.
Rectification in gender of the proposer/ policyholder / Insured Person.
Rectification in relationship of the Insured Person with the proposer/ policyholder.
Rectification of date of birth of the Insured Person (if this does not impact the premium).
Change in the correspondence address of the proposer/ policyholder / Insured Person.
Change/updation in the contact details viz., phone number, E-mail ID, etc.
Updation of alternate contact address of the proposer/ policyholder / Insured Person.
Change in Nominee details.
Addition/ Deletion/ updation of GSTIN
Change in occupation (if this does not impact the premium)
Change/ rectification in Account number
Change of Policyholder
b) Financial Endorsements – which result in alteration in premium
Deletion of Insured Person on death if no claims are paid / outstanding.
Deletion of Insured Person
Rectification of date of birth of the Insured Person.
Addition of member (New Born Baby/ Newly wedded spouse/ partner)
Addition of member
Change in the correspondence address of the Proposer/ Policyholder / Insured Person.
Rectification in gender of the Proposer/ Policyholder / Insured Person.
Change of Policyholder
Change in occupation

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

32. Electronic Transactions

The Insured Person agrees to adhere to the terms and conditions and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of Us for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.

These terms and conditions shall be within the approved Policy Terms and Conditions.

However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI (Protection of Policyholders Interests) Regulations 2017, as may be amended from time to time. All conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form, all necessary disclosures on terms, conditions and major exclusions shall be made known to the Insured Person.

33. Communications & Notices

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

a. You/ Insured Person, at the address as specified in Policy Schedule/ Certificate of Insurance.

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

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

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

34. Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment (unless assigned by the Policyholder) or other dealing with or relating to this Policy. The payment made by Us to You/ Insured Person or to their Nominee/ legal representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or Benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

35. Grievances Redressal Procedure

If You/Insured Person may have a grievance that requires to be redressed, You/ Insured Person may contact Us with the details of the grievance through:

Our website:www.manipalcigna.com

Email: servicesupport@manipalcigna.com

Toll Free : 1800-102-4462

Courier: Any of Our branch office or corporate office during business hours.

You/Insured Person may also approach the grievance cell at any of Our branches with the details of the grievance during Our working hours from Monday to Friday.

If You/Insured Person are not satisfied with Our redressal of Your grievance through one of the above methods, You/Insured Person may contact Our Head of Customer Service at The Grievance Cell, ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited) Reg.Office:401/ 402,4th Floor,Raheja Titanium,Off Western Express Highway,Goregoan (East), Mumbai- 400 063 or email -headcustomercare@manipalcigna.com or call us at 1800-102-4462 or call at +91 22 6170 3600

If You/Insured Person are not satisfied with Our redressal of grievance through one of the above methods, You/Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

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

36. Anti-Corruption

Notwithstanding any provision in this Policy or otherwise, it is agreed that We shall have no liability or obligation where We reasonably believe such would violate any applicable law, regulation or order, including but not limited to, anti-corruption laws and programs imposing financial sanctions on targeted individuals, entities, or nations, including (without limitation) any relevant (1) resolution of the United Nations Security Council and/or any implementation thereof in any jurisdiction, (2) law, regulation, and/ or order administered by the Department of Treasury of the United States of America, and/or (3) regulation issued by the European Council and/or any implementation thereof in any jurisdiction. We shall have no liability or obligation and this Policy shall, at Our election, be deemed void where any actions in furtherance of the Policy is prohibited. Furthermore, We are under no obligation to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws. Furthermore, We shall not pay claims for services received in sanctioned countries if doing so would violate the requirements of the United States Department of Treasury's Office of Foreign Assets Control, or the United Nations Security Council Sanctions Committees.

Annexure I – Ombudsman

Office of The Governing Body of Insurance Council (Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, Santacruz (West), Mumbai - 400054. Tel.: 26106671/6889. Email ID: inscoun@ecoi.co.in. Web: www.ecoi.co.in If you have a grievance, approach the grievance cell of Insurance Company first. If complaint is not resolved/ not satisfied/ not responded for 30 days then you can approach The Office of the Insurance Ombudsman (Bimalokpal). Please visit our website for details to lodge complaint with Ombudsman.

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, Ahmedabad-380 001. Tel.:- 079-25501201/02/05/06 Email:- bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Bldg,PID No.57-27-N-19 Ground Floor,19/19,24th Main Road, JP Nagar, 1st Phase Bengaluru – 560 078, Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market , Bhopal – 462 003. Tel.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubneshwar – 751 009. Tel.:- 0674-2596461/2596455/ Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:- bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@ecoi.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23232481/23213504 Email:- bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr Panbazaar over bridge Road, Guwahati – 781001 (ASSAM)Tel.:- 0361-2632204 / 2602205 Email:- bimalokpal.guwahati@ecoi.co.in	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.:- 040-67504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Email:- Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759/9338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email:- bimalokpal.kolkata@ecoi.co.in	West Bengal, , Sikkim, and Andaman and Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330/1 Fax:- 0522-2231310 Email:- bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022-26106552/6960 Fax:- 022-26106052 Email:- bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & 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:0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Bldg., Bazar Samiti Road, Bahadurpur, Patna 800006. Tel: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 -41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure II – Non Medical Expenses

SNO	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy	SUGGESTIONS
TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient

47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.	Exclusion in policy unless otherwise specified
61	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
62	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
63	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
64	HOSPITALIZATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
65	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
66	STEM CELL IMPLANTATION/ SURGERY and STORAGE	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
67	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
68	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
69	MICROSCOPE COVER	Payable under OT Charges, not separately
70	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
71	SURGICAL DRILL	Payable under OT Charges, not separately
72	EYE KIT	Payable under OT Charges, not separately
73	EYE DRAPE	Payable under OT Charges, not separately
74	X-RAY FILM	Payable under Radiology Charges, not as consumable
75	SPUTUM CUP	Payable under Investigation Charges, not as consumable
76	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
77	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
78	ANTISEPTIC or DISINFECTANT LOTIONS	Not Payable -Part of Dressing Charges
79	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable -Part of Dressing Charges
80	COTTON	Not Payable -Part of Dressing Charges
81	COTTON BANDAGE	Not Payable -Part of Dressing Charges
82	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
83	BLADE	Not Payable
84	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
85	TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
86	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
87	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
88	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
89	HVAC	Part of room charge not payable separately
90	HOUSE KEEPING CHARGES	Part of room charge not payable separately
91	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately

92	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
93	SURCHARGES	Part of Room Charge , Not payable separately
94	ATTENDANT CHARGES	Not Payable - Part of Room Charges
95	IM IV INJECTION CHARGES	Part of nursing charges, not payable
96	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
97	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
98	BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES		
99	ADMISSION KIT	Not Payable
100	BIRTH CERTIFICATE	Not Payable
101	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
102	CERTIFICATE CHARGES	Not Payable
103	COURIER CHARGES	Not Payable
104	CONVENYANCE CHARGES	Not Payable
105	DIABETIC CHART CHARGES	Not Payable
106	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
107	DISCHARGE PROCEDURE CHARGES	Not Payable
108	DAILY CHART CHARGES	Not Payable
109	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
110	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
111	FILE OPENING CHARGES	Not Payable
112	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
113	MEDICAL CERTIFICATE	Not Payable
114	MAINTENANCE CHARGES	Not Payable
115	MEDICAL RECORDS	Not Payable
116	PREPARATION CHARGES	Not Payable
117	PHOTOCOPIES CHARGES	Not Payable
118	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
119	WASHING CHARGES	Not Payable
120	MEDICINE BOX	Not Payable
121	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
122	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
123	WALKING AIDS CHARGES	Payable when prescribed
124	BIPAP MACHINE	Payable when prescribed
125	COMMODE	Payable when prescribed
126	CPAP/ CAPD EQUIPMENTS	Payable when prescribed
127	INFUSION PUMP - COST	Payable when prescribed
128	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Payable when prescribed
129	PULSEOXYMETER CHARGES	Payable when prescribed
130	SPACER	Payable when prescribed
131	SPIROMETRE	Payable when prescribed
132	SP 02 PROBE	Payable when prescribed
133	NEBULIZER KIT	Payable when prescribed
134	STEAM INHALER	Payable when prescribed
135	ARMSLING	Payable when prescribed
136	THERMOMETER	Payable when prescribed
137	CERVICAL COLLAR	Payable when prescribed
138	SPLINT	Payable when prescribed
139	DIABETIC FOOT WEAR	Payable when prescribed

140	KNEE BRACES (LONG/ SHORT/ HINGED)	Payable when prescribed
141	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Payable when prescribed
142	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
143	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadripiegia for any reason and at reasonable cost of approximately Rs 200/ day
144	AMBULANCE COLLAR	Payable if required in an emergency when an ambulance is required
145	AMBULANCE EQUIPMENT	Payable if required in an emergency when an ambulance is required
146	MICROSHEILD	Payable when prescribed
147	ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
148	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\ DSINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
149	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
150	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by hospital is payable
151	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
152	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
153	Digestion gels	Payable when prescribed
154	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT o r ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
155	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
156	HIV KIT	Payable - payable Pre-operative screening
157	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
158	LOZENGES	Payable when prescribed
159	MOUTH PAINT	Payable when prescribed
160	NEBULISATION KIT	If used during hospitalization is payable reasonably
161	NOVARAPID	Payable when prescribed
162	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
163	ZYTEE GEL	Payable when prescribed
164	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
165	AHD	Not Payable - Part of Hospital's internal Cost
166	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
167	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
168	VACCINE CHARGES FOR BABY	Not Payable
169	AESTHETIC TREATMENT / SURGERY	Not Payable
170	TPA CHARGES	Not Payable
171	VISCO BELT CHARGES	Not Payable
172	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
173	EXAMINATION GLOVES	Not Payable
174	KIDNEY TRAY	Not Payable
175	MASK	Not Payable
176	OUNCE GLASS	Not Payable
177	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
178	OXYGEN MASK	Not Payable
179	PAPER GLOVES	Not Payable
180	PELVIC TRACTION BELT	Should be payable in case of PIVID requiring traction as this is generally not reused
181	REFERAL DOCTOR'S FEES	Not Payable
182	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitalization or post hospitalization / Reports and Charts required / Device not payable

183	PAN CAN	Not Payable
184	SOFNET	Not Payable
185	TROLLY COVER	Not Payable
186	UROMETER, URINE JUG	Not Payable
187	AMBULANCE	Payable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
188	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs an d then 1 in 24 hrs
189	URINE BAG	Payable w here medically necessary till a reasonable cost - maximum 1 per 24 hrs
190	SOFTOVAC	Not Payable
191	STOCKINGS	Essential for case like CABG etc. where it should be paid.

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For any assistance, contact 1800-102-4462 servicesupport@manipalcigna.com www.manipalcigna.com

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