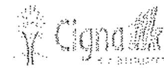

Cigna TTK Global Health Group Policy
Policy Terms and Conditions

CignaTTK Health Insurance Company Limited
Registered office: 10th Floor, Commerz, Int. Business Park, Oberoi Garden City,
Off. Western Express Highway, Goregaon (E), Mumbai 400063

I. Preamble & Operating Clause

This is a legal contract between the Policyholder and Us subject to the receipt of premium, Disclosure to Information Norm including the information provided by the Policyholder in the Group Proposal Form and the terms, conditions and exclusions of this Policy.
If any Claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable, then We shall indemnify Medical Expenses incurred for the listed Benefits in accordance with terms, conditions and exclusions of the Policy subject to availability of the Sum Insured.

II. Benefits under the Policy

The Policy agrees to indemnify the Medical Expenses for the Benefits listed below incurred in respect of an Insured Person towards any covered Illness or Injury during the Policy Period that are listed under this Policy and advised by a Medical Practitioner.
The Policy provides coverage which includes In-patient, Day Care and Out-patient Medical Expenses recommended by a Medical Practitioner, and which are Medically Necessary.

Coverage shall be available as per the applicable plan as specified in the Schedule to this Policy in respect of an Insured Person subject always to, the Sum Insured and any subsidiary limit specified in the Benefit Table.

Basic Covers

II.1 In-patient Hospitalization

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Hospitalization arising from an Accident or Illness for more than 24 consecutive hours:

i. Room charges up to the Category/Limit as per Plan opted and specified in the Schedule to this Policy,
ii. Charges for accommodation in ICU/CCU/HDU,
iii. Operation theatre cost,
iv. Medical Practitioner fees,
v. Specialist fee,
vi. Surgeon's fee,
vii. Anaesthetist fee,
viii. Radiologist fee,
ix. Pathologist fee,
x. Assistant Surgeon fee,
xi. Qualified Nurses fee,
xii. Medication,
xiii. 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.
xiv. Surgical appliance and/or Medical Appliance.

If the Insured Person is admitted in a room category or in a room where the rent is higher than the one that is specified in the Schedule to this 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 V 4 & 5.

II.2 Day Care Expenses
We will pay the Reasonable and Customary Charges for the Medical Expenses of an Insured Person in case of a Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours Hospitalization undertaken in a Hospital/nursing home/Day Care Centre on the recommendation of a Medical Practitioner. In respect of US based admissions, We will also pay the Reasonable and Customary Charges for Major or Minor Surgical Procedures in respect of an Insured Person carried out in a Medical Practitioner's clinic. For the purpose of coverage in India the list of Day Care Procedures are listed under Annexure II.
All Claims under this benefit can be made as per the process defined under Section V 4 & 5.

II.3 Surgical Contraception/Sterilisation and Vasectomy
We will pay the Reasonable and Customary Charges for the Medical Expenses of an Insured Person towards implanted/injected contraceptives post appropriate counselling, Medically Necessary Expenses connected with surgical therapies including but not limited to Tubal Ligation, Vasectomies including any associated medical expenses.
All Claims under this benefit can be made as per the process defined under Section V 4 & 5.

II.4 Pre-existing Disease
All Pre-existing Diseases as defined in the Policy, will be covered from inception of the Policy unless otherwise specifically opting for a waiting period in which case the coverage will be applicable post 48 months of continuous coverage with Us.

II.5 Home Nursing charges
We will pay the Reasonable and Customary Charges for the cost of a Qualified Nurse arranged by the Hospital to visit the Insured Person's home to give expert nursing services:

- Immediately after the Insured Person's Hospitalization/Treatment for as long as is required by medical necessity; and
- Visits for as long as it is required by medical necessity for Treatment which would normally be provided in a Hospital.

In either case, the specialist Medical Practitioner who treated the Insured Person must have recommended these services in writing. This cover is not related to any Domiciliary Hospitalisation.
All Claims under this benefit can be made as per the process defined under Section V 5.

II.6 Organ Transplant Expenses
Subject to the conditions set out below, We will pay the Reasonable and Customary Charges incurred during human to human organ transplantation towards solid organs and bone marrow/stem cell transplant procedures in accordance with the following:

- *Insured Person as an organ recipient* – We will pay for the recipient Insured Person's In-patient Hospitalization medical expenses, immunosuppressive medications, and the donor's medical costs and costs for organ or bone marrow/stem cell procurement.
- *Insured Person as an organ donor* – We will pay the donor Insured Person's In-patient Hospitalization medical expenses, donor screening, costs for organ or bone marrow/stem cell procurement and other related Medical Expenses. We will not cover the costs for the organ recipient under such circumstances.

Conditions

- We will only pay the Reasonable and Customary Charges for the costs directly related to the procurement of an organ, bone marrow/stem cell from a cadaver or a live donor, namely the costs

relating to surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor.

- We will only pay for compatibility testing undertaken prior to procurement if the same is Medically Necessary. We will also pay for the costs related to the search and identification of a bone marrow or a stem cell donor for an allogeneic transplant in respect of an Insured Person.
- Any experimental procedures shall not be covered under this Benefit.
- Costs associated with experimental procedures will not be covered.

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

II.7 Parental Accommodation

We will pay Reasonable and Customary Charges for reasonable accommodation expenses in respect of one parent/legal guardian, to stay with any minor Insured Person (under the Age of 18) for up to 30 days in any Policy Year. The Policy covers such expenses provided the Treatment a minor Insured Person receives is covered by the Plan. This Benefit will cease on the date of a minor Insured Person's 18th birthday.
All Claims under this benefit can be made as per the process defined under Section V 4 & 5.

II.8 New Born Cover

We will pay the Reasonable and Customary Charges towards Hospitalisation Expenses for a baby who is within the first 30 days of its life following delivery. Following the 30 day New Born Benefit period the child will be required to be covered under the policy by way of addition of dependant all premiums due being paid.
All Claims under this benefit can be made as per the process defined under Section V 4 & 5.

II.9 AIDS/ HIV Cover

We will pay the Reasonable and Customary Charges for the Medical Expenses that arise from, or are in any way related to, 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 in respect of an Insured Person.
Medical Expenses covered by the Policy are limited to pre and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), Hospital accommodation and nursing fees.
Testing for AIDS/HIV will only be paid if medically requested i.e. if the patient is showing symptoms.

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

II.10 Psychiatric & Psychological Care

We will pay the Reasonable and Customary Charges up to limit of Sum Insured as specified under the Plan opted, for In-patient Treatment in respect to an Insured Person in a recognised psychiatric unit of a Hospital or Out-Patient treatment including Specialist consultations. All Treatment under this Benefit must be pre-authorised by Us in writing and must at all times be administered under the direct control of a registered psychiatrist.
All Claims under this benefit can be made as per the process defined under Section V 4 & 5.

II.11 Private Ambulance

We will pay the Reasonable and Customary Charges for costs incurred in shifting an Insured Person from residence to the Hospital for admission in Emergency Ward or ICU or for shifting the Insured Person from one Hospital to another Hospital for better medical facilities.
All Claims under this benefit can be made as per the process defined under Section V 4 & 5.

II.12 Out of Area Cover

We will pay the Reasonable and Customary Charges for the Medical Expenses that arise due to an emergency while the Insured Person is outside the opted Area of Cover, limited to a maximum period of 30 days starting from the date such movement outside the eligible area of coverage.

All out of area expenses will be payable only if it is pre-authorised by Us.
All Claims under this benefit can be made as per the process defined under Section V 4

II.13 International Emergency Services
All Emergency medical Evacuations and/or Repatriations must be pre-authorised by the Our medical team. Where it is not possible for pre-authorisation to be sought before the evacuation takes place, this must be sought as soon as possible thereafter. We will only authorise medical evacuations after the evacuation has occurred where it was not reasonably possible for authorisation to be sought before the evacuation took place.

(a) Emergency Evacuations
Subject to the conditions set out below in case of an Emergency in respect of an Insured Person if adequate medical facilities are not available locally, We will arrange for an Emergency evacuation of the Insured Person to the nearest facility capable of providing adequate care. We will also cover the reasonable cost of travel (transport only) for any individual who, due to medical necessity, must accompany the Insured Person. In addition, We will cover the reasonable cost of travel incurred for the return journey (economy class) of the Insured Person and such person accompanying the Insured Person after receipt of appropriate Treatment.

The Medical Assistance Service will arrange for the transport of the Insured Person to the nearest Hospital offering the necessary Treatment, under proper medical supervision.
Medical evacuations must be determined by Our medical team to be Medically Necessary to prevent the immediate and significant effects of Illness, Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the Treatment is not available locally. In making Our determinations, We will consider the nature of emergency, Your medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of your evacuation to be considered an emergency and requiring emergency evacuation. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

(b) Medical Repatriation
Following any covered Emergency evacuation, We reserve the right to request the repatriation of the Insured Person to a Hospital in the Insured Person's country of domicile or to the original work location or the location from which the Insured Person was evacuated when a Medical Practitioner named by the Medical Assistance Service, after speaking with a local attending Medical Practitioner, decides that the Insured Person is fit to undertake the journey. We will pay Reasonable and Customary Charges for the most economical cost of travel (transport only) for the Insured Person and any individual who, because of medical necessity, has to accompany the Insured Person. If such transportation needs to be medically supervised, a qualified medical attendant will escort the Insured Person. If any mode of transportation other than the above is required and it is determined by the attending Medical Practitioner and agreed by the Medical Assistance Service, We will arrange accordingly and such will be covered by Us.

Medical repatriation must be determined by Our Medical team to be Medically Necessary to prevent the immediate and significant effects of Illness, Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the treatment is not available locally, and that it is necessary for medical reasons for the Insured Person to be returned to his/her country of domicile, the Medical Assistance Service will arrange for the transport under proper medical supervision as soon as reasonably practicable.

(c) Repatriation of Mortal Remains

We will cover the costs associated with the transportation of mortal remains from the place of death to the home country. In addition, assistance will be provided by Us or the Medical Assistance Service for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

All Claims under this benefit can be made as per the process defined under Section V 15.

II.14 Out-Patient Expenses

We will pay the Reasonable and Customary Charges for the following Out-patient expenses in respect of an Insured Person:

xv. **Diagnostic tests such as Laboratory tests, Radiology and pathology, MRI's, CAT Scan's PET Scan's**

xvi. **Consultations with Medical Practitioners and specialist Medical Practitioners;**

xvii. **Prescribed prescriptions, medicines, drugs and dressings;**

xviii. **Non-surgical & minor Surgical Procedures and Treatment;**

xix. **Complementary Treatments - Physiotherapy, Acupuncture, Chiropody, Osteopathy, Homeopathy as specified in the Plan opted.**

xx. **Non-surgical and Minor Surgical Procedures and Treatments.**

We will require a specialist Medical Practitioner's referral to be included whenever filing a claim for the following Treatments:

- Physiotherapy Treatment -;
- Chiropractic Treatment -;
- Acupuncture Treatment - other than a specialist of complementary medicine;
- Osteopathic Treatment - other than a specialist of complementary medicine; and
- Homeopathic Treatment - other than a specialist of complementary medicine.

vii. Hormone Replacement Therapy

We will pay Reasonable and Customary Charges for costs of Medically Necessary *treatment* in respect of an Insured Person for Hormone Replacement Treatment. However, this Benefit will not cover unproven or experimental methods or procedures.

viii. Child Annual Eye & Hearing tests

We will pay the Reasonable and Customary Charges for an annual eye and hearing test for the Insured Person's dependent children below the Age of 15 years.

ix. Travel Vaccinations

We will pay the Reasonable and Customary Charges for the following vaccinations and inoculations in respect of an Insured Person:

- Tetanus - every 10 years;
- Hepatitis A;
- Hepatitis B;
- Meningitis;
- Rabies;
- Cholera;
- Yellow fever;
- Japanese encephalitis;
- Polio booster;
- Typhoid; and
- Malaria - tablet form, daily or weekly.

The above list is indicative. We may cover additional vaccination costs in respect of medically necessary vaccinations toward the Insured Person as mandated before undertaking any travel.

x. Emergency Dental Treatment

In case of requirement of Emergency dental Treatment due to an Accidental dental Injury in respect of an Insured Person, We will pay the Reasonable and Customary Charges for dental *Treatment* received during the first Emergency visit immediately after Accidental damage to natural teeth.

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

Any Treatment that arises from or is in any way connected with attempted suicide or any injury or illness that the Insured Person or dependant inflicts upon himself, that is paid under any of the above benefits under Section II1. To II.14 is limited to an upper lifetime limit of ₹ 10000000per Insured Person.

II.15 Area of Cover

The Policy provides the following options for the applicable Areas of Cover. The Policy Schedule 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.

Areas of Cover	a) India , Africa, Middle East, Oceania, Asia (excluding China, HongKong, Singapore, Japan, Taiwan) b) India, Europe, Canada, Latin America, Caribbean c) Worldwide Excluding United States d) Worldwide Including United States*

* For the Area of Cover specified at 'd' above a minimum Sum Insured of ₹ 2,50,00,000 must be opted.

III. Optional Covers

The Policy provides the following optional covers which can be opted individually or in combination.
Once selected on a policy the selected option shall apply to all persons in the policy without any individual selection.

The Policy Schedule will specify the Optional Covers that are in force for the Group.

III.1 Pre-existing Diseases Waiting Period Addition

The Policy provides an option to add a waiting period towards Pre-existing diseases/Illness/Injury until 48 months of continuous covers have elapsed since inception of the first Policy with Us.

III.2 Deductible

The Policy provides for a Deductible in the Policy where, We will indemnify the Medical Expenses incurred in excess of the Deductible for the listed Benefits in respect of the Insured Person. The deductible limit will apply to an Insured Person for each Policy Year on the aggregate of all Claims payable in that Policy Year in respect of In-Patient/Day Care, Out-Patient as well as Maternity Claims.
The Policy Schedule will specify the Deductible option that is selected by the group and is in force for the Insured Person.

Deductible shall not apply to Optional Benefits under Option III.6, III.7, III.8 wherever opted.

III.3 Co-pay

The Policy provides for a 20% Co-pay in the Policy. If the Co-pay is in force, We will be liable to pay only 80% of the admissible amount that We assess for the payment in respect of any Claim under the Policy and the balance 20% will be borne by the Insured Person.

The Policy Schedule will specify the applicable Co-pay that is selected by the group and is in force for the Insured Person.

Co-pay shall not apply to Optional Benefits under Option III.6, III.7, III.8 wherever opted.

III.4 Maximum limit on Out of Pocket Expenses

The Policy provides for an Out of Pocket Maximum limit, which shall be the maximum amount an Insured Person will bear out of his pocket during the Policy Period.

The amount borne by an Insured Person under the Co-pay and/or Deductible option (if any in force) will be deducted from the Out of Pocket Maximum Limit applicable. Once the Out of Pocket Maximum Limit has been exhausted in respect of an Insured Person, all further admitted claims in respect of that Insured Person for the same Policy Period will be paid without the application of a Co-pay or Deductible.

This feature is only available for selection where an Insured person has opted for a Deductible and/ or Co-pay.

III.5 Maternity Expenses

The Policy provides an option for coverage of Medical Expenses arising from Maternity claims. We will pay the Reasonable and Customary Charges for the below listed Maternity expenses if this Optional Benefit is in force for the Insured Person. Only Eligible Females who are Insured Persons will be eligible for cover under this Optional Benefit. The Policy Schedule will specify if the Maternity expenses cover is in force for the Insured Person.

a. Routine or Elective Caesarean Cost

The Policy covers voluntary caesarean section costs and Medically Necessary caesarean costs due to any previous non-Emergency caesarean sections undertaken.

b. Complicated Pregnancy

The Policy covers Treatment of a medical condition arising during the antenatal stages of pregnancy, a medical condition arising during childbirth and that requires a recognised obstetric procedure, and post natal check-ups as a result of the complication of pregnancy for up to six weeks. Complications arising as a result of infertility treatment (assisted conception) are excluded from this Benefit.

c. Pre & Post Natal Care

The Policy covers the cost of pre and post-natal check-ups for up to six weeks, prescribed pre natal vitamins and delivery costs. All costs relating to complications of pregnancy or childbirth following infertility treatment (assisted conception) will be limited to this Benefit.

d. Newborn Cover

This Benefit extends to include neo-natal care, new born packages (including elective circumcision) and costs incurred for the care of the baby or babies until discharge from the hospital following birth when the baby is accompanying its Eligible Female Insured Person mother whilst she is receiving Treatment as an In-patient in a Hospital.

e. Maternity Assistance & Mid-wife charges

The Policy covers qualified midwives charges.

f. Birthing Classes Charges

The Policy covers cost of professional birthing classes.

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

III.6 Wellness

The Policy provides the following coverage under the Wellness Tests option. Wherever opted, the Policy Schedule will specify if any of the following Wellness Tests cover is in force for the Insured Person.

a. Routine Adult Physical Exams

We will pay the Reasonable and Customary Charges in respect of an Insured Person for routine check-ups/tests for blood and cholesterol, height/weight body mass index, resting blood pressure, urine analysis, cardiac examination, exercise electrocardiogram (ECG), other vital organ function tests, and chest x-ray.

b. Well Child Test

We will pay the Reasonable and Customary Charges for tests towards an Insured dependent child who is Aged 6 or less for charges made for the purpose of preventive care, consisting of the following services delivered or supervised by a Medical Practitioner, which services amount to orthodox treatment:

- Medical history of the Insured dependent child;
- Physical examination;
- Development assessment;
- Anticipatory guidance; and
- Immunisations (as listed below) and laboratory tests.
    - DPT (Diphtheria, Pertussis and Tetanus)
    - MMR (Measles, Mumps and Rubella)
    - HiB (Haemophilus influenza Type b)
    - Polio
    - Influenza
    - Hepatitis B
    - Meningitis
    - Human Papilloma Virus (HPV)
    - Tetanus - every 10 years
    - Hepatitis A
    - Hepatitis B
    - Meningitis
    - Rabies
    - Cholera
    - Yellow fever
    - Japanese encephalitis
    - Polio booster
    - Typhoid
    - Malaria - tablet form, daily or weekly

The following charges are excluded under this Benefit:

- More than one visit to a Medical Practitioner for child preventive care services at each of the appropriate Age intervals up to a total of 13 visits for each Insured dependent child;
- Services for which Benefits are otherwise provided under this Plan.

c. Pap Smear

We will pay Reasonable and Customary Charges for an annual papanicolaou screening, commonly known as a pap smear, for Eligible Female Insured Persons over 35 years of Age.

d. PSA Test

We will pay Reasonable and Customary Charges for an annual prostate screening, commonly known as a prostate specific antigen (PSA) test for male Insured Persons that are Aged 50 or older.

e. Mammograms for Breast Cancer Screening or Diagnostic Purposes

We will pay Reasonable and Customary Charges for mammograms for breast cancer screening or diagnostic purposes in respect of Eligible Female Insured Persons but not exceeding:

a. one baseline mammogram for asymptomatic Eligible Female Insured Persons Aged 35 to 39;
b. a mammogram for asymptomatic Eligible Female Insured Persons Aged 40 to 49, every two years or more, if Medically Necessary;
c. a mammogram every year for Eligible Female Insured Persons Aged 50 or over.

All Claims under this benefit can be made as per the process defined under Section V 14.

III.7 Dental

7.1 The Policy provides for the following coverage towards Dental Treatments. Wherever opted, the Policy Schedule will specify if any of the following Wellness Tests cover is in force for the Insured Person including the available Sum Insured under each of the benefits.

a. Class 1 (Investigative & Preventative Treatment)

Under this Benefit, We will pay Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for carrying out the following routine Dental Treatment procedures in respect of an Insured Person:

- Clinical Oral examinations;
- Palliative treatment for dental pain
- Minor Procedures
- tooth cleaning;
- normal compound fillings; or
- simple non-surgical extractions.

This Benefit excludes orthodontic treatment, restorative treatment and dental implants.

b. Class 2 (Basic Restorative, Periodontal Treatment)

Under this Benefit We will pay the Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for the Treatment of the following specified procedures in respect of an Insured Person:

- Amalgam Filling
- Composite/Resin Filling
- Root Canal Treatment
- Osseous Surgery
- Periodontal Scaling & Root Planning
- Adjustments
- Recement Bridge
- Routine Extractions
- Surgical removal of impacted tooth
- Local or general Anaesthesia including Sedation

This Benefit excludes orthodontic treatment, routine treatment and dental implants.

c. Class 3 (Major Restorative & Orthodontic Treatment)

Under this Benefit We will pay the Reasonable and Customary Charges to cover fees of a dental practitioner carrying out restorative Dental Treatment and associated costs for the following specified procedures in respect of an Insured Person:

- removal of impacted or buried teeth;
- removal of roots;
- removal of solid odontomes;

- apicectomy;
- new or repair of bridge work;
- new or repair of crowns;
- root canal treatment;
- new or repair of upper or lower dentures;
- removal of wisdom teeth.

Orthodontic Treatment includes Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
This benefit excludes dental implants.

All Claims under this benefit can be made as per the process defined under Section V 14 except for Claims towards Dependent Children below 18 years in respect of Orthodontic Treatment where Pre-Authorisation is mandatory.

Exclusions Applicable to Dental Benefit

We will not pay benefit for the following treatment

i. replacing any dental appliance which is lost or stolen;
ii. replacing a bridge, crown or denture which is or can be made useable according to a standard acceptable to a dentist of ordinary competence and skill;
iii. replacing a bridge, crown or denture within five years of original fitting unless:
iv. the replacement is needed because of the placement of an original opposing full denture or extraction of natural teeth is needed; or
v. the bridge, crown or denture, while in the mouth, has been damaged beyond repair because of an injury the employee or their dependant receives while covered under the Policy.
vi. porcelain or acrylic veneers on the upper and lower first, second and third molars and premolars;
vii. crowns or pontics on or replacing the upper and lower first, second and third molars unless- they are constructed of either porcelain bonded-to-metal or metal alone, e.g. gold alloy crown; or o a temporary crown or pontic is required as part of routine or emergency dental treatment.
viii. surgical implants of any type including any attaching prosthetic device;
ix. procedures and materials which are experimental or which do not meet accepted dental standards;
x. instruction for plaque control, oral hygiene and diet;
xi. procedures, services and supplies which are deemed by Us to be medical procedures, services and supplies including mouthwashes and also including services and supplies provided in a hospital (except where dental treatment is neither wholly nor partly the reason for the stay in hospital);
xii. bite registration, precision or semi-precision attachments;
xiii. procedures, appliances or restorations (except full dentures) whose main purpose is to:
    - change vertical dimensions; or
    - diagnose or treat conditions or dysfunction of the temporo-mandibular joint or
    - stabilise periodontally involved teeth; or
    - restore occlusion.
    - major treatment on deciduous or baby teeth for dependent children;

III.8 Vision

The Policy provides an option for coverage of Vision Tests. The Policy Schedule will specify if the Vision Test cover is in force for the Insured Person including the available Sum Insured under each benefit.
If the Vision Test cover is in force in respect of an Insured Person, We will Pay the Reasonable and Customary Charges for the following Medical Expenses incurred in respect of that Insured Person:

- one eye examination by an optometrist or ophthalmologist per Policy Year;
- the provision of lenses to correct vision;
- the provision of eyeglass frames.

This Benefit will exclude:

- sunglasses, unless medically prescribed by a Medical Practitioner;
- medical or surgical treatment of the eye;
- lenses which are not a medical necessity and are not prescribed by an optometrist or ophthalmologist or frames for such lenses.

All Claims under this benefit can be made as per the process defined under Section V 14.

IV. Waiting Period & Permanent Exclusions

IV.1 Pre-existing Disease Waiting Period

All Pre-existing Diseases / Illness / Injury / conditions as defined in the Policy, until 48 months of continuous covers have elapsed since inception of the first Policy with Us. This waiting period shall apply only if the optional cover for pre-existing waiting period is specifically applicable to the plan and is specified in the Schedule to this Policy.

IV.2 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:

1. Any Treatment that arises from or is in any way connected with attempted suicide or any injury or illness that the Insured Person or dependant inflicts upon himself other than the limit specified under the Table of Benefits above..

2. Treatment for or in connection with speech and/or occupational therapy unless it:

- is recommended by a specialist/ Medical Practitioner, and
- is intended to restore skills which previously existed and have been lost as a result of an acute medical condition,
- has a reasonable likelihood of being restored

3. Dental or orthodontic Treatment unless specifically in force under the Policy for the Insured Person.

4. Treatments in nature cure clinics, health spas and nursing homes (except for nursing homes registered in India).

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. Hospital accommodation costs that are more expensive than those of a Private Room at the same hospital subject to limits specified under the plan. Wherever a room category higher than the one eligible under the plan is used, Charges for such room costs will be apportioned.

7. Any Treatment directly related to surrogacy. We will not pay for expenses arising in respect of

- an Insured Person who acts as a surrogate
- anyone else acting as a surrogate for an Insured Person

8. Any Treatment needed because of; or relating to male or female birth control which is not specifically covered under the Policy.

9. Any Treatment needed because of or relating to infertility or any type of fertility treatment, including complications arising out of such treatment, with the exception of the investigation of infertility to the point of diagnosis.

10. Any Treatment by way of the intentional Termination of Pregnancy, unless two Medical Practitioners certify in writing that the pregnancy were to endanger the life or mental stability of the Insured Person.

11. 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.

12. Any Treatment to change the refraction of one or both eyes, including refractive keratotomy (RK) and photorefractive keratectomy (PRK).

13. Injury or disability directly or indirectly caused or contributed to whilst engaging in or taking part in war, invasion, terrorist activities, rebellion (whether war be declared or not), civil war, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority, or while the Insured Person or dependants are carrying out army, naval or air services operations, whether or not war has been declared.

14. Any Treatment outside the selected Area of Coverage if one of the reasons the Insured Person travelled was for that treatment, except if the Medical Assistance Service has arranged emergency evacuation or medical repatriation approved by Us.

15. Any form of non-emergency travel costs in respect of an Emergency Evacuation or Repatriation specifically payable under International Emergency Services.

16. Any expenses for International Emergency Services which were not intimated and approved in advance by Us.

17. 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.

18. 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

19. Any expenses for ship-to-shore evacuations.

20. 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.

21. 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 basis; or

- solo scuba-diving or scuba diving at depths below 30 metres unless the diver is PADI qualified (or equivalent) for that depth.

22. Any form of Unproven/Experimental Treatment (or procedure) that does not amount to orthodox treatment.

23. Any Treatment for or in connection with developmental disorders, including but not limited to:
- developmental reading disorders
- developmental arithmetic disorders
- developmental language disorders
- developmental articulation disorders

24. Any Treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or cognitive or developmental disabilities or disorders.

25. Expenses relating to:
- any form of sterilisation or contraception including vasectomy unless specifically covered in the Policy
- any form of plastic, cosmetic or reconstructive surgery or treatment, even for psychological reasons, unless it is Medically Necessary as a direct result of the Insured Person having an Accident or because of other Surgery, which itself would have been covered under the Plan
- appliances (including spectacles unless the vision benefit has been selected and hearing aids) which do not fall within Our definition of surgical appliance and/or medical appliance
- hearing tests, except for one hearing test per annum for a dependent child under the age of 15 years
- incidental costs including newspapers, taxi fares, telephone calls, guests' meals and hotel accommodation
- eye tests except for one eye test per annum for a dependent child under the age of 15 years
- costs for treatment that has not yet taken place irrespective of whether advance authorisation has been given or a Cashless Autorisation has been put in place

26. We will not offer cover or pay for any Benefits when it is illegal to do so under applicable laws.

V. Claims procedure

V.1. Condition Precedent

The fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied 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.

V.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. 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 V.3, V.4, V.5, as mentioned below.
(b) Follow the directions advice or guidance provided by a Medical Practitioner. We shall not be obliged to make any payment(s) that are brought about or contributed to, as a consequence of failure to follow such directions, advice or guidance.
(c) If so requested by Us, 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

V.3 Claim Intimation
In the event of a Claim under the policy, the Insured Person must notify Us either at the call center or in writing,
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 the Us 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

V.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 or Injury which are covered under the Policy.
For all Cashless authorizations, Insured Person will, in any event, be required to settle all non-admissible expenses, Co-payment and / or Deductibles (if applicable), directly with the Hospital.

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 Employee ID/ Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the 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 authorisation We shall issue the authorisation Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a **period of 6 hours** from the receipt of last complete documents.
f. The Authorisation letter will include details of Amount Sanctions, any specific limitation on the claim, any applicable Co-pays or Deductibles and non-payable items if applicable.
g. The authorisation letter shall be valid only for period of 15 days from the date of issuance of the authorization.

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

i. The Network Provider shall request Us for an enhancement of authorisation limit as described under V.4 a. 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 V.4 a. above.

At the time of discharge:

i. The Network Provider may forward a final request for authorization for any residual amount to us along with the Insured Person's discharge summary and the billing format in accordance with the process described at V.4 a. above.
ii. Upon receipt of the final authorisation letter from us, Insured person may be discharged by the Network Provider.

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 V.4 a. 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.

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-authorisation request
c. Copy of pre-authorisation approval letter (s)
d. Copy of Photo ID of Patient Verified by the Hospital
e. Original discharge/death summary;
f. Operation theatre notes(if any);
g. Original hospital main bill and break up of the bill;
h. Original investigation reports, X Ray, MRI, CT Films and HPE;
i. Doctors reference slips for investigations/pharmacy;
j. Original pharmacy bills;MLC/FIR report/post mortem report (if conducted).

The Documents listed above will apply for claims in India, however for claims arising due to Hospitalisation of the Insured Person outside of India the requirements may vary based on the Provider Agreements between the Service Partner and the Network Provider.
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 terms and conditions of this Policy.

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

V.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.

- Claim form duly completed and signed;
- Hospital discharge summary;
- Operation theatre notes;
- Hospital main bill;
- Hospital break up of bill;
- Original investigation reports, X Ray, MRI, CT films, HPE, ECG;
- Doctors reference slip for investigation;
- Pharmacy bills;
- MLC/ FIR report/post mortem report, if applicable.

We may call for any additional documents/information as required based on the circumstances of the claim.
Our branch offices shall give due acknowledgement of collected documents to the Insured person.

b. If the submission of claim documents as specified in V.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 requirement for certain documents may be waived based on local market practise.

V.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 may at Our sole discretion decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if We observe that such a claim is otherwise valid under the Policy.
e. In case a reimbursement claim is received when a pre-authorization letter has been issued 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.

V.7 Claim Assessment

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

a. If the provisions of the Contribution Clause apply, under Section VI.19, Our liability to make payment under the claim shall be first apportioned accordingly.
b. 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.
c. Subsequent to applying V.7 i) and ii) to the admissible claim amount, the following cost sharing mechanisms will be applied sequentially if applicable -
   - Opted deductible.- Opted Co-pay
   For Optional Coverage under Dental Option III, the internal deductible limit will be applied first.
d. At any given stage if the Insured person's total cost sharing amount under V.7 (iii) above is equal to the opted Out of Pocket Maximum (OOP) 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.

V.8 Re-opening of Claim

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

V.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 6 months from the date of receipt of claim intimation. 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.

V.10 Settlement & Repudiation of a claim

We shall settle a Claim including its rejection within 30 days of the receipt of the last "necessary" documents

In case of suspected frauds, the last "necessary" document shall mean the receipt of verification/ investigation report to determine the validity of the claim as stated in V.9 above.

In the cases of delay in the payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

V.11 Representation against Rejection

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

V.12 Claims falling in 2 policy periods

If a hospitalisation 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 the Policyholder has renewed the Policy with Us for the subsequent year.

V.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 Period.

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

c. 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.

d. 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.

e. For Reimbursement Claims, the payment will be made to 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 where discharge shall be treated as full and final discharge of Our liability under the Policy.

V.14 Wellness, Dental & Vision Benefit Claim

The Insured Person shall avail these benefits as defined in section III.6, III.7 & III. 8, 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-authorisation is a must.

For Claims in respect of Orthodontic Treatment towards dependent children below 18 years, the employee or dependant 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.

Any benefit will be payable only if We have authorised the cover before treatment starts

V.15 Emergency evacuation & Medical repatriation –

a) In the event of an Insured Person requiring Emergency evacuation and 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 Medical specialists in association with the Emergency Assistance Service Provider shall determine the Medical Necessity of such Emergency Evacuation or Repatriation post which the same will be approved.

VI. Terms and conditions

VI.1 Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable 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 by the Policyholder/ 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.

VI.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 the Policyholder or any of the Insured Persons, shall be the condition precedent to Our liability under this Policy.

VI.3 Reasonable Care

The Insured Person understands and agrees to take all reasonable steps in order to safeguard against any Accident or Illnesses that may give rise to any claim under this Policy.

VI.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.

VI.5 Material Information for administration

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 benefit provided under the plan. Billing for the plan will be processed on the exact number of Insured Persons covered under the policy. You must give Us written notification by the 5th day of each calendar month in the Policy Period 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 the Policyholder 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 the Policyholder is 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 contract.

VI.6 Eligibility

To be eligible for coverage under the plan, the Insured Person must be-

- Be an Employee of the Policyholder nominated and sponsored by the Policyholder which is a registered Company in India. .
- In the age group of 18 to 75 years. Persons above 65 years and up to 75 years may be added as Insured Persons on a case to case basis upon satisfactory underwriting by Us.

- New born babies will be accepted for cover (subject to the limitations of the new born benefit) from birth. Acceptance of new born babies 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.
- Dependants as defined in the Policy will be eligible for coverage under the Plan. Dependant Spouse can be covered from age 18 years to 75 years at the time of entry. Dependent Children can be covered from day 1 of birth up to 25 years of age. Dependent Parents are not eligible for coverage.

VI.7 Dependant Coverage

Employees and their Dependents are required to be covered under the same group plan with identical benefits.

VI.8 No Constructive Notice

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

VI.9 Geography

The geographical scope of this policy applies to events limited to the Geographical Area of Cover opted and which are specified in the Schedule to the Policy.

VI.10 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.

VI.11 Premium

The premium payable under this policy shall be paid in accordance with the schedule of payments agreed between the Policyholder and Us. No receipt for premium shall be valid except on the official form of Insurer signed by a duly authorized official of Insurer. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a condition precedent to any liability of Insurer 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.

VI.12 Free Look period

A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. 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 full premium. 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.

VI.13 Parties to the Contract

The only parties to this contract are the Policyholder and Us.

VI.14 Currency

The monetary limits applicable to this policy will be expressed in the same currency as the insurance premium. Claims paid on a local currency will be converted at the spot exchange rate on the date of payment.

VI.15 Addition and Deletion of a Member

In respect of cover and billing for employees or dependants (where applicable) who are joining or leaving the plan, We will apply the following format:

Additions

- Any Insured Person who joins the Plan during the first 15 days of a contract month, will be covered as an Insured Person from the date of joining but will be billed for the entire month.
- Any Insured Person who joins the Plan as an Insured Person during the last 15 days of a contract month, will be covered from the date of joining but will not be billed for that month whereupon billing will commence at the beginning of the following month.

Deletions

- Any Insured Person who leaves the Plan during the first 15 days of a contract month, will be covered up to the date of leaving but will not be billed for that month.
- Any Insured Person who leaves the Plan during the last 15 days of a contract month, will be covered up to the date of leaving but will be billed for the entire month.

Any Addition/Deletion of unmarried partners will be allowed only once during the policy period along with proof of contractual documents.

Throughout the period of this policy, the Policyholder will notify Us of all and any changes in the membership of the plan 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 the Policyholder advises 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 and/or dependents and the same will be paid before the actual start date of the cover in respect of those employees. 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.

VI.16 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 IRDA approval. If the policy changes because of new laws, We will write and tell the Policyholder. In all circumstances, We will give the following notice:

- for changes to the list of benefits, at least 90 days' notice in writing;
- for changes to the policy terms and conditions, or ending the plan, at least 90 days' notice in writing. The change will take place, failing which the plan 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.

VI.17 No Constructive Notice

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

VI.18 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 receives such claims We will have the right to apply the Contribution clause while settling the claim.

VI.19 Subrogation

The Policyholder 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.

VI.20 Grace Period & Renewal

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy 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 Renewal premium 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 we will terminate the cover for the specific employee and his/her dependants including further renewals and continue the cover for the remaining group members while bringing such instances to the knowledge of the Policyholder. Where it is found that the Policyholder is involved in such above situations, the complete Policy will be terminated.

Revival Period:

For instalment premium policies, the revival period shall be 15 days. 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 Change in Plan or Optional Covers, can be requested at the time of renewal of the Group Plan. We reserve our right to carry out assessment of of the group and provide the renewal quote in respect of the revised plan opted.
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 renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDA.

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 IRDA and in accordance with the IRDA rules and regulations as applicable from time to time. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

VI.21 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 term as per the short period scale mentioned below.
Premium shall be refunded only if no claim has been made under the Policy.

1 Year	
Policy in force upto	**Premium Refund %**
1 Month	75%
3 months	50%
6 months	25%
More than 6 months	Nil

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.

VI.22 Our Right of Termination

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

- where the number of employees first falls below 5
- when We give the Policyholder at least 15 days' notice that the policy is to end
- if the Policyholder does not pay the premiums owed under the policy within the days of grace
- For Non-Indian Nationals returning to their country of domicile member will be eligible for coverage under the applicable plan for coverage until the end of the policy or earlier if specifically terminated by the employer.

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 plan ends or an employee or dependant leaves the plan 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 policies.

Termination for Insured Person's cover

a. On Immediate basis

Cover will end for an Employee

- If the Insured Person dies. The Policyholder may agree to continue cover for their dependants up to the next annual renewal date when their cover will end
- If the Insured Person stops working for the Policyholder
- If the Policyholder stops paying premiums for Insured Person and their dependants (if any)
- When this policy terminates at the expiry of the period shown in the Policy Schedule

Cover will end for a Dependant

- If he or she dies
- When he or she ceases to be a dependant;
- If the Insured Person stops working for the Policyholder

b. At the next annual renewal date
Cover will end for an Employee
If an employee gets divorced or the unmarried partners no longer live together or a civil partnership is dissolved, the spouse or unmarried or civil partner will no longer be considered as a dependant for the purposes of this policy.
Cover will end for the Spouse
Cover for the spouse ends as soon as the final decree/final dissolution order has been granted.

VI.23 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.

VI.25 Fraudulent Claims
If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent 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. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

VI.26 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.

VI.27 Portability
All health insurance policies are portable.-An Insured Person under this Policy can port to an approved Retail Health Policy available with Us at the time of such portability for the purpose of coverage within India only, provided that:

a. The Insured Person has been covered under this Policy.
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. We should have received the application for Portability with complete documentation at least 45 days before the expiry of the present period of Insurance
d. We may subject such proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.
e. There is no obligation on Us to insure all Insured Persons on the proposed terms, even if we have received all the documentation

After maintaining the retail policy with Us for a period of one year Insured Person may port the policy to any other product offered by other insurers in the market.

VI.28 Electronic Transactions
The Policyholder/ Insured agrees to comply with all the terms, conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other products and services, shall constitute legally binding when done in compliance with Our terms for such facilities.
Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder/ Insured Person. A voice recording in case of tele-sales or other evidence

for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder/ Insured Person.

VI.29 Communications & Notices

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

a. The policyholder, at the address as specified in Schedule
b. To Us, at the address specified in the Schedule.
c. No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.
d. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

VI.30 Complete Discharge

We will not be bound to take notice or be affected by any Notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to 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.

VI.31 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.cignattkinsurance.in
Email: customercare@cignattk.in
Toll Free: 1-800-10-24462
Fax: 022 40825222
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, CignaTTK Health Insurance Company Limited, 10th Floor, Commerz, Int. Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai 400063 or email headcustomercare@cignattk.in

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.

VI.32 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

VII. Definitions

1. **Age or Aged** means the last birthday, and which means completed years as at the Inception Date or the Joining date for the Insured Person
2. **Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external visible and violent means
3. **Annual Renewal Date** means the anniversary of the Inception date each year or any other date which We agree and the Policyholder may agree in writing.
4. **Alternative Treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context
5. **Annexure** means a document attached and marked as Annexure to this Policy
6. **Acute condition** - means 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.
7. **Ambulance** means a road vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
8. **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 may have been taken..
9. **Area of Cover** means Geographic coverage area as defined under Section II.2
10. **Benefit** means any benefit shown in the list of benefits
11. **Cashless Facility** means a facility extended by the Insurer to the Insured Person where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
12. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
    - *Internal Congenital Anomaly* - which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly
    - *External Congenital Anomaly* - which is in the visible and accessible parts of the body is called External Congenital Anomaly
13. **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.
14. **Co-pay/ Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the Insured Person will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.
15. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's Liability under the Policy is conditional upon.
16. **Cosmetic Surgery** means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
17. **Chronic Condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    —it needs on going or long-term monitoring through consultations, examinations, check-ups, and / or tests
    —it needs on going or long-term control or relief of symptoms
    — it requires the Insured person's rehabilitation or for them to be specially trained to cope with it
    —it continues indefinitely
    —it comes back or is likely to come back.
18. **Day Care Treatment** refers to medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required a hospitalization of more than 24 hours.

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

19. **Day Care Centre** means any institution established for Day Care Treatment of Illness and / or Injuries or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-
    -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.
20. **Deductible** A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
21. **Dental emergency** - where severe pain that is not relieved by painkillers, or facial swelling or uncontrollable bleeding after an extraction, is being suffered and it is either outside the business hours of the employee or dependant's usual dentist or the employee or dependant is staying at a place which is away from the dental practice they usually visit. The treatment covered in such an instance is to purely stabilise the problem and relieve severe pain.
22. **Dental injury** - injury to the employee or dependant's dentition and supporting structures (including damage to dentures while being worn) caused by extra-oral impact.
23. **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.
24. **Dependent** means the employee's spouse or unmarried civil/contractual partner or child who has been enrolled in the Plan.
25. **Dependent Child** refers to a child (natural or legally adopted), who is under Age 25, either in full-time education or residing at the same residence as the Employee at the commencement of any treatment and is financially dependent on the Employee. 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.
26. **Disclosure to Information Norm**
    The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
27. **Dental Treatment** is a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of Cosmetic Surgery/implants.
28. **Eligibility** means the provisions of the Policy that state the requirements to be complied with.
29. **Eligible Female** is a person who is a female Employee or a female Spouse or unmarried civil/contractual partner of an Employee.
30. **Employee** means any member of Your staff under who is proposed and sponsored by You who becomes an Insured Person.
31. **Emergency Care** means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
32. **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.
33. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.

34. **Grace Period** is 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.
35. **Home nursing** is arranged by the hospital for a qualified nurse to visit the patient's home to give expert nursing services immediately after hospital treatment for as long as is required by medical necessity, visits for as long as is required by medical necessity for treatment which would normally be provided in a hospital.
    In either case, the specialist who treated the patient must have recommended these services.
36. **HDU** - High dependency unit is 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.
37. **Hospital (International)** is any organisation which is registered or licensed as a medical or surgical hospital in the country in which it is located and where the patient is under the daily care or supervision of a medical practitioner or qualified nurse and does not include a nursing home.
38. **Hospital (India)** means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act OR complies with all minimum criteria as under:
    - has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    - has qualified nursing staff under its employment round the clock;
    - has qualified medical practitioner(s) in charge round the clock;
    - has a fully equipped operation theatre of its own where surgical procedures are carried out
    - maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
39. **Hospitalisation or Hospitalised** means admission in a Hospital for a minimum period of 24 in- patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
40. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
41. **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.
42. **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 dependants (if any)
43. **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.
44. **In-patient** means an Employee Or Dependent who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving treatment.
45. **Insured Person** means the Employee or Dependents named in the Schedule to this Policy, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.
46. **Intensive Care Unit** means an identified section, ward or wing o f a hospital which is under the constant supervision o f 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.
47. **Latin America** – Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Falkland Islands, French Guiana, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, Venezuela
48. **Maternity Expense** shall include the following:
    - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);
    - Expenses towards lawful medical termination of pregnancy during the Policy Period

49. **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.
50. **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.
51. **Medical Advice** means any written consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
52. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advise of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.
53. **Medical Practitioner -** A Medical Practitioner is a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
54. **Medically Necessary** 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 Person;
    - 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.
55. **Network Provider** means hospitals or health care providers enlisted by an Insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.
56. **Non-Network** means any hospital, day care centre or other provider that is not part of the network.
57. **New Born Baby** means those babies born to the Insured Employee and their spouse during the Policy Period Aged between 1 day and 90 days, both days inclusive.
58. **Notification of Claim** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.
59. **Oceania** – Australia, Fiji, Kiribati, , Marshall Islands, Micronesia, Nauru, New Zealand, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu
60. **Operation** means any procedure described as an operation in the schedule of surgical procedures.
61. **Out-Patient** means a patient who undergoes OPD treatment.
62. **OPD treatment** is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
63. **Orthodox -** in relation to a procedure or treatment that is medically accepted in the United Kingdom at the time of the commencement of the procedure or treatment, in that it accords with that upheld by a respectable, responsible and substantial body of medical opinion, experienced in the particular field of medicine.
64. **Private Room** means a single occupancy accommodation in a private hospital.
65. **Plan -** CignaTTK Global Health Benefits Policy.
66. **Policy** is sent to You comprising of Policy wordings, Certificates of Insurance issued to the Insured Persons, group Proposal 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.
67. **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.
68. **Policy Year** means a period of 12 consecutive months commencing from the Inception Date.

69. **Premium** shall have to be paid in Indian Rupees and made in favour of CignaTTK Health Insurance Company Ltd.
70. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
71. **Pre-Existing Disease** is any condition, ailment or injury or related condition(s) for which the Insured Person may have had signs or symptoms, and / or was diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the Insurer.
72. **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 for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer.
73. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India; 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.
74. **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.
75. **Room Rent** shall mean the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall not include any associated medical expenses.
76. **Renewal** defines 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 all waiting periods.
77. **Spouse** - the employee's legal husband or wife, or unmarried or civil partner accepted for cover under the plan.
78. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.
79. **Specialist** is a doctor 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.
80. **Short-term** means a period of time consistent with the recuperation time required for the treatment and as prescribed by the treating medical practitioner with the approval of Cigna's medical director.
81. **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.'
82. **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.
83. **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 of suffering or prolongation of life, performed in a hospital or day care centre by a Medical Practitioner
84. **TPA** means any person who is licenses under the IRDA (Third Party Administrators – Health Services) Regulations 2001 by the Authority, and is engaged, for a fee or remuneration by Us, for the purposes of providing health services.

85. **Treatment** - any relevant treatment controlled by a medical practitioner to cure or substantially relieve acute or chronic conditions within the scope of the plan.
86. **Unproven/Experimental Treatment** - is treatment, including drug Experimental therapy, which is not based on established medical practice in India or the USA.
87. **We/Our/Us** means the CignaTTK Health Insurance Company Limited
88. **You/Your/Policyholder** - the person named in the Schedule who has concluded this Policy with Us.

Annexure I – Ombudsman

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, AHMEDABAD-380 014. Tel.:- 079-27546150/139 Fax : 079-27546142 Email ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)-462 023. Tel.:- 0755-2769200/201/202 Fax : 0755-2769203 Emailbimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455/61 Fax : 0674-2596429 Email ioobbsr@dataone.in	Orissa
CHANDIGARH	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.:-0172-2706196/5861/6468 Fax: 0172-2708274 Email: ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet,	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)

	CHENNAI-600 018. Tel.:- 044-24333678/664/668Fax: 044-24333664 Email: chennaiinsuranceombudsman@gmail.com	
NEW DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-239611/7539/7532Fax: 011-23230858 Email: iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.:- 0361-2132204/2131307/2132205 Fax: 0361-2732937 Email: ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel: 040-23325325/23312122 Fax: 040-23376599 Email: insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358734/759/9338 Fax : 0484-2359336 Email: iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, Kolkatta – 700 072. Tel: 033- 22124346/39 Fax: 033- 22124341 Email: insombudsmankolkata@gmail.com	West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim

LUCKNOW	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel: 0522 -2201188/31330/1 Fax: 0522-2231310 Emailinsombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel: 022-26106928/360/6552/6960 Fax: 022-26106052 Email: ombudsmanmumbai@gmail.com	Maharashtra, Goa

Annexure II - Day Care Expenses Applicable to India

List of Day Care Treatments/Surgeries/Procedures

Microsurgical Operations on the middle ear

1. Stapedotomy to treat various lesions in the middle ear
2. Revision of Stapedotomy 21. Other operations on the nose
3. Other operations of the auditory ossicles
4. Myringoplasty (post-aura/ endural approach as well as simple
5. Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicle)
6. Revision of a Tympanoplasty 24. Incision of tear glands
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

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

Operations on the nose & the nasal sinuses

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

Operations on the eyes

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

Operations on the skin & subcutaneous tissues

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

Operations on the tongue

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

Operations on the salivary glands & salivary ducts

65. Incision and lancing of a salivary gland and a salivary duct

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

Other operations on the mouth & face

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

Operations on tonsils and adenoids

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

Operations on the breast

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

Operations on the digestive tract, Kidney and bladde

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

Operations on the female sexual organs

105. Incision of the ovary

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

Operations on the prostate & seminal vesicles

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

Operations on the scrotum & tunica vaginalis testis

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

Operations on the testes

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

Operations on the spermatic cord, epididymis and ductus deferens

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

Operations on the penis

146. Operations on the foreskin
147. Local excision and destruction of diseased tissue of the penis

148. Amputation of the penis
149. Other operations on the penis

Operations on the urinary system
150. Cystoscopical removal of stones
151. Catheterisation of bladder

Other Operations
152. Lithotripsy
153. Coronary angiography
154. Biopsy of Temporal Artery for Various lesions
155. External Arterio-venus shunt
156. Haemodialysis
157. Radiotherapy for Cancer
158. Cancer Chemotherapy
159. Endoscopic polypectomy

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

Annexure III – 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	M01STUR1SER 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 SPECIFIC ALL Y 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	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	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		

75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	ANTISEPTIC or DISINFECTANT LOTIONS	Not Payable -Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable -Part of Dressing Charges
88	COTTON	Not Payable -Part of Dressing Charges
89	COTTON BANDAGE	Not Payable -Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge , Not payable separately

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

	OUTSIDE THE HOSPITAL)	
137	PULSEOXYMETER CHARGES	Payable when prescribed
138	SPACER	Payable when prescribed
139	SPIROMETRE	Payable when prescribed
140	SP 02 PROBE	Payable when prescribed
141	NEBULIZER KIT	Payable when prescribed
142	STEAM INHALER	Payable when prescribed
143	ARMSLING	Payable when prescribed
144	THERMOMETER	Payable when prescribed
145	CERVICAL COLLAR	Payable when prescribed
146	SPLINT	Payable when prescribed
147	DIABETIC FOOT WEAR	Payable when prescribed
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Payable when prescribed
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Payable when prescribed
150	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
151	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
152	AMBULANCE COLLAR	Payable if required in an emergency when an ambulance is required
153	AMBULANCE EQUIPMENT	Payable if required in an emergency when an ambulance is required
154	MICROSHEILD	Payable when prescribed
155	ABDOMINAL BINDER	Essential an d 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 PA YABLE IF SUPPORTED BY A PRESCRIPTION		
156	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
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed

162	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.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164	HIV KIT	Payable - payable Pre-operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVID requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports an d Charts required / Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable

195	AMBULANCE	Payable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs an d then 1 in 24 hrs
197	URINE BAG	Payable w here medically necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.