ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151 **Call** (Toll Free): 1800-102-4462
Visit: www.manipalcigna.com **E-mail:** customercare@manipalcigna.com

MANIPALCIGNA PROHEALTH INSURANCE PROSPECTUS

I. What are the Key Highlights of the Policy?

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II. What are the Basic covers?

i) In-patient Hospitalisation
We will cover medical expenses in case of medically necessary hospitalisation of an Insured person incurred due to Disease, Illness or injury when the Insured person is admitted as an in-patient for more than 24 consecutive hours provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Year. The coverage will include reasonable and customary charges towards room rent for accommodation in a hospital, up to limits specified under the eligible Room Category under the Plan opted, charges for accommodation in Intensive Care Unit and operation theatre charges, fees of medical practitioner, anaesthetist, qualified nurses, specialists, the cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending medical practitioner that are used intra operatively during a surgical procedure.

Under the Protect and Accumulate Plan coverage is available up to a Single Private Room for Sum Insured Up to ₹5.5 Lacs.
Under the Protect, Accumulate with Sum Insured ₹7.5 Lacs and above, Plus, Preferred and Premier Plan accommodation under any Room Category will be available excluding a suite or higher category.

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

ii) Pre - hospitalisation
We will reimburse medical expenses of an Insured person due to a disease or injury or illness that occurs during the PolicyYear incurred immediately prior to hospitalisation, up to the limits specified under the plan opted by the Insured subject to a claim being admissible under In-patient Hospitalisation and expenses are related to the same illness/condition.

iii) Post - hospitalisation
We will reimburse medical expenses of an Insured person incurred post hospitalisation due to a disease or injury or illness that occurs during the Policy Year up to the limits specified under the plan opted by the Insured subject to a claim being admissible under In-patient Hospitalisation and expenses are related to the same illness/condition.

iv) Day Care Treatment
We will cover payment of medical expenses of an Insured Person in case of medically necessary day care treatment or surgery that requires less than 24 hours hospitalisation due to advancement in technology and which is undertaken in a hospital / nursing home/day care centre on the recommendation of a medical practitioner. Any treatment in an outpatient department (OPD) is not covered. The list of Day Care Treatments/ Procedures is available as an Annexure to the policy. Coverage will also include pre-post hospitalisation expenses as available under the Plan opted.

v) Domiciliary Treatment
We will cover medical expenses of an Insured person for treatment of a disease, illness or injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable. This is provided that the condition would otherwise have been covered for hospitalisation under the Policy and for which treatment is required continues for at least 3 days and is on the advice of a medical practitioner. Claims for pre-hospitalisation expenses, post-hospitalisation up to 30 days each. We shall not be liable under this policy for any claim in connection with or in respect of the following:

- Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
- Arthritis, gout and rheumatism,
- Chronic nephritis and nephritic syndrome,
- Diarrhoea and all type of dysenteries, including gastroenteritis,
- Diabetes mellitus and insipidus,
- Epilepsy,
- Hypertension,
- Psychiatric or psychosomatic disorders of all kinds,
- Pyrexia of unknown origin.

vi) Ambulance Cover
We will cover the reasonable and customary expenses incurred for transportation of an Insured person by an ambulance service provider to the hospital for treatment covered under the Policy following an emergency, requiring the Insured Person's admission to a Hospital. The coverage will be up to the limits specified under the plan opted by the Insured. Limits specified under this benefit will be applicable per Hospitalisation and necessity must be certified by the attending Medical Practitioner.

vii) Donor Expenses
We will cover in-patient hospitalisation medical expenses towards the donor for harvesting the organ in case of major organ transplant if it is in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules. The organ donated is for the use of the Insured person per Medical Advice and a claim has been admitted under in patient hospitalisation. However, Pre-Post hospitalisation expenses towards the donor, cost towards donor screening, cost directly or indirectly associated to the acquisition of the organ or any other medical treatment

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for the donor consequent on the harvesting will not be covered.

viii) Worldwide Emergency Cover

We will cover medical expenses incurred during the policy year for emergency treatments for an illness or injury sustained or contracted outside of India which cannot be postponed until the Insured Person has returned to India up to limits specified under the plan opted by the Insured and admissible under In Patient Hospitalisation cover as per the terms of the Policy.

Such treatment received outside India should be medically necessary and has been certified as an emergency by a medical practitioner and intimation of such hospitalisation has been made to us within 48 hours of such admission.

The medical expenses payable shall be limited to Inpatient hospitalisation and shall be made in India and in Indian Rupees on reimbursement basis.

Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance. In case where Cumulative Bonus accumulated is used for payment of claim under this benefit, the maximum liability under a single Policy year shall not exceed the Opted Sum Insured including Cumulative Bonus or Cumulative Bonus Booster as applicable.

ix) Restoration of Sum Insured

In case the Sum Insured inclusive of earned cumulative bonus (if any) or Cumulative Bonus Booster (if opted & earned) is insufficient due to claims paid or accepted as payable during the policy year, then we will restore 100% of the Sum Insured for any number of times in a policy year. This restored amount can be used for all future claims not related to the illness/disease/injury for which a claim has been made in the particular policy year for the same Insured Person. Restoration will not trigger on the first claim.

In case the Restored Sum Insured is not utilised in a policy year, it shall not be carried forward to subsequent policy year. Any restored Sum Insured will not be used to calculate the Cumulative Bonus or Cumulative Bonus Booster. For Individual policies restored Sum Insured will be available on individual basis whereas in case of a floater it will be available on floater basis.

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

a. The Sum Insured
b. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)

During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:

a. The Sum Insured
b. Cumulative Bonus (if earned) or Cumulative Bonus Booster(if opted & earned)
c. Restored Sum Insured

Restoration will not trigger in case of a claim under Maternity, New Born Baby and First Year Vaccinations.

x) AYUSH Cover

We will pay the Medical Expenses incurred during the Policy Year in case of Medically Necessary Treatment taken during In-patient Hospitalisation for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

i. The Insured Person has undergone AYUSH Treatment in a government Hospital or in any institute recognised by government and/or accredited by Quality Council of India/ National Accreditation Board on Health.
ii. Teaching hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
iii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the state/ UT and complies with the following as minimum criteria:
    a) Has at least fifteen in-patient beds
    b) Has minimum five qualified and registered AYUSH doctors
    c) Has qualified paramedical staff under its employment round the clock

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

xi) Health Maintenance Benefit (HMB)

We will cover, only by way of reimbursement costs towards Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred during the Policy Year on:

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

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

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

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

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

xii) Maternity Expenses

We cover Maternity Expenses for the delivery of a child and/or maternity expenses incurred during the Policy Year related to medically necessary and lawful termination of pregnancy limited to maximum 2 deliveries during the lifetime of an Insured person between 18 years to 45 years, subject to limits under the plan opted by the Insured.

The Insured person should have been continuously covered under this policy for at least 48 months before availing this benefit, except in case of opting for 'Reduction in maternity waiting' where the limit will be relaxed to 24 months of waiting.
Maternity Sum Insured will be limited to per event and in addition to Sum Insured opted under the Policy, however any restored amount will not be available for coverage under this section.
Applicable Deductible or Co-pay under the plan shall also apply to this benefit.

The following expenses are not covered under maternity benefit:

a. Medical expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.
b. Medical expenses for ectopic pregnancy. However, these expenses will be covered under the inpatient hospitalisation.

xiii) New Born Baby Expenses

We cover medical expenses towards treatment of the Insured person's new born baby while the Insured Person is hospitalised as an in-patient for delivery, subject to a valid claim being accepted under maternity expenses.
This would include in-patient hospitalisation expenses incurred on the new born baby during and post birth including any complications up to a period of 90 days from the date of birth and within the limits specified under Maternity Expenses cover under the plan opted by You.
We would cover the baby beyond 90 days on payment of requisite premium subject to addition of the baby into the policy by way of an endorsement or at the next renewal whichever is earlier.
Applicable Deductible or Co-pay under the plan shall also apply to this benefit.

xiv) First Year Vaccinations

We will cover vaccination expenses of the new born baby as per National Immunisation Scheme (India), until the new born baby completes one year (i.e.12 months). The coverage will be subject to claims admitted under maternity expenses cover and will be in addition to the Maternity Sum Insured available under the Plan. However maximum liability under the policy shall not exceed the opted Sum Insured. Any restored Sum Insured will not be available for coverage under this section.
If the policy ends before the new born baby has completed one year, then, such vaccinations shall be covered until the baby completes 12 months, subject however to the Policy being renewed in the subsequent year.

The reasonable and customary charges for standard vaccinations will be covered as per below schedule:

Time Interval	Vaccinations to be done (Age)	Frequency
0 – 3months	BCG (Birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2
3 – 6 months	OPV (14 week) OR OPV + IPV2	1 or 2
	DPT (14 week)	1
	Hepatitis-B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

III. What are the Value Added Covers?

i) Health Check Up

We will provide for a comprehensive Health Check-Up as listed in the eligibility table below, to all Insured Persons who are 18 years of age. Heath Check Ups will be available irrespective of their claim status under the policy and will be arranged by Us at Our network providers. The coverage under this benefit will not be available on reimbursement basis.

For Protect & Accumulate plan –available once every 3rd Policy year.
For Plus, Preferred and Premier Plan –available once each year, excluding the first policy year.

Sum Insured	Age	List of tests
Protect, Plus & Accumulate Plan Sum Insured ₹*2.5 Lacs, ₹3.5 Lacs, ₹4.5 Lacs, ₹5.5 Lacs,*	>18 years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT
Protect, Plus & Accumulate Plan Sum Insured ₹*7.5 Lacs, ₹10 Lacs*	18 to 40 years	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
	> 40 years (For Females Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH
	> 40 years (For Males Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT

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Protect, Plus & Accumulate Plan Sum Insured ₹*15 Lacs and* Above	18 to 40 years (For Females Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH
	18 to 40 years (For Males Only)	Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT
	> 40 years (For Females only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT
	> 40 years (For Males only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT
Preferred & Premier Plan Sum Insured ₹*15 Lacs and* Above	18 to 40 years (For Females Only)	Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, Pap smear, Mammogram
	18 to 40 years (For Males Only)	Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, PSA
	> 40 years (For Females only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, Pap smear, Mammogram, Uric acid, USG Abdomen & Pelvis
	> 40 years (For Males only)	Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT, PSA, Uric acid, USG Abdomen & Pelvis

Full explanation of Tests is provided here: Vitals - Height, Weight, Blood Pressure, Pulse, BMI, Chest Circumference & Abdominal Girth, FBS – Fasting Blood Sugar, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT – Test Serum Glutamic Pyruvate Transaminase, SGOT – Serum Glutamic Oxaloacetic Transaminase, TSH – Thyroid Stimulating Hormone, TMT – Tread Mill Test, PSA – Prostate Specific Antigen

(c) Coverage under this value added cover will not be available on reimbursement basis. All Claims under this benefit can be made as per the process defined under Section VII of Policy Terms and Conditions.

ii) Expert Opinion on Critical Illnesses

We will provide the Insured person the choice to avail of an expert second opinion from Our network of medical practitioners for an Insured person who is diagnosed with a covered critical illness as listed below, during the policy year.

This benefit can be availed once, by each Insured person during an annual policy period and once during the lifetime for the same Critical Illness. Covered Critical Illnesses shall include –

- Cancer of specific severity
- Myocardial Infarction (First Heart Attack of specified severity)
- Open Chest CABG
- Open Heart Replacement or Repair of Heart Valves
- Coma of specified severity
- Kidney Failure requiring regular dialysis
- Stroke resulting in permanent symptoms
- Major Organ/Bone Marrow Transplant
- Permanent Paralysis of Limbs
- Motor Neurone Disease with permanent symptoms
- Multiple Sclerosis with persisting symptoms

iii) Cumulative Bonus

a) On Sum Insured

We will increase the Sum Insured as specified under the Plan opted, at the end of the policy year if the policy is renewed with us. The applicable percentage of Cumulative Bonus is set out under Section IX Table of Benefits:

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

b) On Health Maintenance Benefit for Accumulate Plan

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

- Available HMB value in the current Policy will be total of Unutilised HMB limit plus the Earned Cumulative Bonus and the HMB of Current Policy Year.
- Each Year Cumulative Bonus will be calculated on the balance HMB value at the end of the Policy Year, irrespective of any change in Sum Insured or HMB opted on the Plan.
- If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
- If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated HMB limit plus Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the HMB limit plus Cumulative Bonus that will be carried forward for credit in such Renewed Policy shall be the total of all the Insured Persons moving out.
- If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/individual policies then the Unutilised HMB limit plus Cumulative Bonus of the expiring

Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

- Cumulative Bonus on the HMB limit for Accumulate Plan shall not accrue if the Policy is not renewed with us within the Grace Period.

iv) Healthy Rewards

You can earn reward points equivalent to 1% of premium paid including taxes & levies for each Policy. In addition to this You can accumulate rewards by opting for an array of Our wellness programs listed below, that will help You to assess Your health status and aid in improving Your overall well-being. There will be no limitation to the number of programs one can enrol however Rewards can be earned only once for each specific program by a particular Insured Person in a policy year. Maximum rewards that that can be earned in a single policy period will be limited to 20% of premium paid in the Policy.

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

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

Reward Points, wherever offered under any specific Sponsored Program will be the same for all customers.
Each earned reward point will be valued at 1 Rupee. Accumulated reward points can be redeemed in the following ways –

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

Refer Annexure for Healthy Reward Process for details of delivery mechanism.

IV. What are the Optional Covers?

The following optional covers shall be available under the Policy and shall apply to all Insured Persons under a single policy without any individual selection.

i) Hospital Daily Cash Benefit

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

a. The hospitalisation claim is admissible under the Base cover.
b. The Benefit will be available up to the maximum 30 days per Policy Year.
c. The Benefit under this cover will be over and above the Sum Insured under Section II.

ii) Deductible

We provide an option of selecting a deductible amount as per the Plan opted. Wherever a Deductible option is selected, such deductible amount will be applied on each policy year on the aggregate of all admissible claims in that policy year.

The deductible options under the various plans are listed below -

Protect & Plus plan: ₹ 1 Lac, ₹ 2 Lacs & ₹ 3 Lacs ₹ 4 Lacs, ₹ 5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs.

Accumulate plan: 50k, ₹ 1 Lac, ₹ 2 Lacs, ₹ 3 Lacs, ₹ 4 Lacs, ₹ 5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs.

Note: Voluntary Co-pay will not be available along with the Deductible option on the same policy.

Deductible shall apply to all sections other than Hospital Daily Cash Benefit, Health Maintenance Benefit, Health Check Up benefits and Add On Riders if opted.

Waiver of Deductible:

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

- Opt out of deductible Within 48 Months

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

- Opt out of deductible After 48 Months:

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

iii) Reduction in Maternity Waiting

We provide option to the Insured person to reduce the mandatory waiting period on Maternity from 48 months to 24 months from the date of inception of first policy with us, depending upon the plan selected.

In case of opting for this benefit, the new born baby cover and first year vaccinations will also follow reduction in waiting period under maternity cover and coverage under both the features will be capped as per the limits specified under Maternity Sum Insured as opted by the insured. All other terms, conditions and exclusions under Maternity Cover shall apply.

iv) Voluntary Co-pay

Irrespective of the age and number of claims made by the Insured person and subject to the co-payment option chosen by you, it is agreed that we will only pay 90% or 80% of any amount that we assess (payable amount) for the payment or reimbursement in respect of any claim under the

policy made by that Insured person and the balance will be borne by the Insured person. Co-pay will be applied on the admissible claim amount. In case You have selected the Voluntary co-pay and/or if You chooses to take treatment out of Zone then the co-pay percentages will apply in conjunction with Section V (vii).

Co-pays shall not apply to Hospital Daily Cash Benefit, Critical Illness Add On (if opted), Health Check Up's and Health Maintenance Benefit

v) Waiver of Mandatory Co-pay
We will provide an option to remove Mandatory co-pay under Section V. (viii), which is applicable for persons aged 65 years and above will be available on payment of additional premium.

vi) Cumulative Bonus Booster
We will provide an option to increase the Sum Insured by 25% for each policy year up to a maximum of 200% of Sum Insured provided that the policy is renewed with us without a break.

- No cumulative bonus will be added if the policy is not renewed with us by the end of the grace period. The cumulative bonus will not be accumulated in excess of 200% of the sum insured under the current policy with us.
- Any earned Cumulative Bonus will not be reduced for claims made in the future. Wherever the earned cumulative bonus is used for payment of a claim during a particular policy year.
- In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III. (iii) shall not be available, however all terms and conditions of the said section shall apply.
- This Cumulative bonus shall not be available for claims made for maternity expenses, new born baby cover, first year vaccination.

Rider/Add On Benefit: Along with this Product You can also avail the ManipalCigna Critical Illness- Add On Cover. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All terms and conditions of applicable rider including medical check-up requirement will apply.

V. What are Features of the Policy?

i) Eligibility
The minimum entry age under this policy is 91 days for children and 18 years for adults. There is no limit for entry under this policy.
Coverage for children:

a. Children from 91 days to 18 years will only be covered if one of the parents is the proposer.
b. Children up to 23 years can be covered under the floater
c. Children beyond 23 years can be covered under an individual policy.

Renewals will be available for lifetime.

ii) Individual and Family Floater
The policy can be purchased on an Individual basis or a Family floater basis.

a. In case of an Individual policy, each Insured person under the policy will have a separate sum insured for them. Individual plan can be bought for self, lawfully wedded spouse, children, parents, siblings, parent in laws, grandparents and grandchildren, son in-law and daughter in-law, uncle, aunty, nephew & niece.
b. In case of a floater cover, one family will share a single sum insured as opted. A floater plan can cover self, lawfully wedded spouse, children up to the age of 23 years or parents. A floater cover can cover a maximum of 2 adults and 3 children under a single policy.

iii) Policy Period option
You can buy the policy for one, two or three continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the inception date of the policy.

iv) Plan & Sum Insured Options
You have the option to choose from a wide range of Sum Insured's available under different plans.

Plan Name	Sum Insured (Lacs)
Protect Plan	₹2.5L, 3.5L, 4.5L, 5.5L, 7.5L, 10L, 15L, 20L, 25L, 30L, 50L
Plus Plan	₹4.5L, 5.5L, 7.5L, 10L, 15L, 20L, 25L, 30L, 50L
Preferred Plan	₹15L, 30L, 50L
Premier Plan	₹100L
Accumulate	₹5.5L, 7.5L, 10L, 15L, 20L, 25L, 30L, 50L

v) Discounts under the Policy
You can avail of the following discounts on the premium on Your policy.

a. Family Discount - of 25% for Protect and Plus Plan and 10% for Preferred, Premier and Accumulate Plans covering 2 and more family members under the same policy under the individual policy option.

b. Long Term policy discount - of a long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy.

c. Worksite Marketing Discount – A discount of 10% will be available on polices which are sourced through worksite marketing channel.

d. Voluntary Co-pay Discount – A discount of 7.5% for opting 10% Co-pay and a discount of 15% for opting a 20% Co-pay on the Policy in case of Protect & Plus Plan.

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

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

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

vi) Underwriting Loading & Special Conditions
We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levis & taxes) based on your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

We may apply a specific sub-limit on a medical condition/ailment depending on Your medical history and declarations or additional waiting periods (a maximum of 48 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy.
We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent and applicable additional premium.

vii) Premiums

The Premium charged on the Policy will depend on the Plan, Sum Insured, Policy Tenure, Age, Policy Type, Gender, Zone of Cover, Optional Covers and Add On Benefits opted. Additionally the health status of the individual will also be considered.

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

For detailed premium chart please refer Annexure "Rate Chart" attached along with this document.

For the purpose of calculating premium, the country has been divided into 3 Zones. Identification of Zone will be based on the City-Location of the correspondence address of the proposed Insured persons and premiums will be calculated accordingly.

Zone Classification

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

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

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

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

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

***Option to select a Zone higher or lower than that of the actual Zone is available on payment of relevant premium at the time of buying the policy or at the time of renewal. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident. Premium towards Maternity Expenses, New born baby expenses and First Year Vaccinations shall be applied to female Insured Members between age group of 18 to 45 years only.

viii) Mandatory Co-pay

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

In case the Insured has selected the Voluntary co-pay under Optional Cover and/or chooses to avail treatment outside his Zone of Cover, then the co-pay percentages will apply in conjunction.

ix) Renewal Terms

a. The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realisation of Renewal premium.

b. The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous policy expiry date and current Policy start date. We, however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy. In case of Accumulate Plan only the unutilised Health Maintenance Benefit limit (excluding any Cumulative Bonus) will be available for a claim during the grace period

c. Where the Policy is not renewed before the end of the Grace Period and the Policy is terminated, any unutilised Health Maintenance Benefit limit in respect of the Accumulate Plan shall be available for a claim as defined under II. (xi) above for up to a period of 12 months from the date of expiry of the Policy.

d. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by You.

e. Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.

f. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.

g. We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

h. Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of members, addition/deletion of Medical Condition existing prior to policy inception will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve our right to carry out underwriting in relation to acceptance of request for changes of Sum Insured or addition/deletion of members, addition/deletion of Medical Condition existing prior to policy inception, on renewal. The terms and conditions of the existing policy will not be altered.

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

j. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 48/ 36/ 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.

k. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section VI. (i) to V. (vi) will be applicable considering such Policy Year as the first year of Policy with the Company.

l. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.

m. Once an Insured Person attains the age of 65 years on renewal a Mandatory co-payment of 20% will be applicable on all claims irrespective of the age of entry in to the Policy. This clause does not apply to persons who have opted for a Waiver of Mandatory Co-pay.

n. In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured under the original Policy.

x) Portability Option

You can port your existing health insurance policy from another company to ProHealth Insurance, provided:

a. You have been covered under an Indian retail health insurance policy from a Non-life Insurance company registered with IRDAI without any break in the immediate previous policy

b. We should have received your application for portability with complete documentation at least 45 days before the expiry of your present period of Insurance

c. If the Sum Insured under the previous policy is higher than the sum insured chosen under this policy, the applicable waiting periods under the Policy shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the Eligible Cumulative Bonus under the expiring health insurance policy.

d. In case the proposed Sum Insured opted for under our policy is more than the insurance cover under the previous policy, then all applicable waiting periods under the Policy shall be applicable afresh to the amount by which the Sum Insured under this Policy exceed the total of Sum Insured and Eligible Cumulative Bonus under the expiring health insurance policy;

e. All waiting periods under the Policy shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

f. If You were covered on a floater basis under the expiring Policy and apply for a floater cover under this Policy, then the Eligible Cumulative Bonus to be carried forward on this Policy shall also be available on a floater basis.

g. If You were covered on an individual basis in the expiring policy then the eligible Cumulative Bonus to be carried forward on this Policy shall be available on an individual basis.

For the purpose of this provision, Eligible Cumulative Bonus shall mean the Cumulative Bonus which You or the Insured Person would have been eligible for had the same policy been renewed with the existing insurance company.
The Portability provisions will be available to You, if you wish to migrate from this Policy to any other health insurance policy on renewals. All benefits under the Policy will terminate on successful porting of the Policy other than any Health Maintenance Benefit under Accumulate Plan which will be available for a claim up to a period of 12 months from the date of expiry of such policy.

xi) Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act 1961. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

xii) Free-look Period

All new individual health insurance policies issued by Us, except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy and

- The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.
- If the insured has not made any claim during the free look period, the insured shall be entitled to—
  a) A refund of the premium paid less any expenses incurred by Us on medical examination of the insured persons and the stamp duty charges or;
  b) where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
  c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

xiii) Cancellations

In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 15 days' notice in writing. We shall refund the premium for the unexpired term as per the short period scale mentioned below.
Premium shall be refunded as per table below if no claim has been registered/ made under the policy and full premium has been received.

	Refund		
In force Period-Up to	**1 Year**	**2 Years**	**3 Years**
0 - 30 Days	75.00%	85.00%	90.00%
31 - 90 Days	50.00%	75.00%	85.00%
91 - 180 Days	25.00%	60.00%	75.00%
181 - 365 Days	NIL	50.00%	60.00%
366 - 455 Days		30.00%	50.00%
456 - 545 Days		20.00%	35.00%
546 - 730 Days		NIL	30.00%
731 - 910 Days			15.00%
More than 910 Days			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, moral hazard, fraud or non-disclosure of material fact without any refund of premium.
Cover may end immediately for all Insured Persons, if there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

An individual policy with a single insured shall automatically terminate in case of Your death or if You are no longer a resident of India. In case of an Individual Policy with multiple Insured Persons and in case of a floater, the Policy shall continue to be in force for the remaining members of the family up to the expiry of current Policy Period. The Policy may be Renewed on an application by another adult Insured Person under the Policy whenever such is due. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with You) must be given to Us along with the Application.
All coverages and benefits including any earned Healthy Reward Points under the Policy shall automatically lapse upon cancellation of the Policy.

Wherever a Policy under the Accumulate Plan is cancelled, any unclaimed Health Maintenance Benefit will be active on the Policy and available for a claim over the next 12 month period. You may convert any available Healthy Reward Points in to Health Maintenance Benefit before initiating the cancellation of the Policy.

xiv) Endorsements

The Policy will allow the following endorsements during the term of the Policy. Any request for endorsement must be made by You in writing. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later other than

for change in Date of Birth or Gender which will be with effect from inception.

a) Non-Financial Endorsements – which do not affect the premium

- Rectification in Name of the Proposer / Insured Person
- Change of Policyholder
- Rectification in Gender of the Proposer/ Insured Person
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not change Zone)
- Rectification in permanent address
- Change of occupation of the insured (if it does not change the risk class of insured)
- Change in height & weight of the insured (if it does not change the risk class of insured)
- Change/Updation in the contact details viz., Phone No., E-mail Id, etc.
- Updation of alternate contact address of the Proposer
- Change in Nominee Details

b) Financial Endorsements – which result in alteration in premium

- Deletion of Insured Member on Death or Separation or Policyholder/Insured Person Leaving the Country only if no claims are paid / outstanding.
- Change in Age/Date Of Birth
- Change of occupation of the insured (if it changes the risk class of insured)
- Addition of Member (New Born Baby or Newly Wedded Spouse)
- Change in Address (resulting in change in Zone)
- Rectification in Gender of the Proposer/ Insured Person
- Disclosure of any illness/ habit
- Change in height & weight of the insured (if it changes the risk class of insured)

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

xv) Grievance Redressal

In case of a grievance , You can contact Us with the details through:
Our website: www.manipalcigna.com
Email: customercare@manipalcigna.com
Toll Free : 1800-102-4462
Fax: 022 40825222
Post/ Courier: Any of Our Branch office or Corporate office at the addresses available on Our website.
You can also walk-in and approach the grievance cell at any of Our branches. If in case You are not satisfied with the response then You can contact Our Head of Customer Service at the following email headcustomercare@manipalcigna.com
If You are still not satisfied with Our redressal, You may approach the nearest Insurance Ombudsman. The Contact details of the Ombudsman offices are provided on Our Website.

xvi) Pre-Policy Medical Check-up

We will require You to undergo a medical check-up based on Your Age, Plan and the Sum Insured opted as provided in the grid below. Wherever any pre-existing disease or any other adverse medical history is declared , We may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age/ Sum Insured/Plan opted. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You

Wherever required we may request for additional tests to be conducted based on the declarations on the proposal form and the results of any medical tests that we have received.

Full cost of all such tests will be borne by us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer we will bear 50% of the cost for such tests.

Plan Name	Sum Insured (Lacs)	Age Group (years)	Medical Tests
Protect, Plus Preferred & Accumulate Plan	2.5L, 3.5L, 4.5L, 5.5L,7.5L, 10L, 15L, 20L, 25L, 30L, 50L	Up to 45	NO TEST
		46 - 55	Tests shall be based on Medical declarations by the Insured and underwriting evaluation.
		> 55	SET 14- MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG
Premier Plan	>50L	Up to 18	SET 1 – MER
		>18	SET 14- MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG

The above list of Medical Tests and age criteria may be modified after due approval from the Head of Underwriting.

Full explanation of Tests is provided here: MER – Medical Examination Report, FBS – Fasting Blood Sugar, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate,

VI. What are the Waiting Period and Exclusions?

We shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following. All waiting periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

i. Pre-existing Disease waiting Period

All Pre-existing Diseases / Illness / Injury / conditions as defined in the Policy, until 24/36/48 (as per Plan opted) months of continuous covers have elapsed since inception of the first Policy with Us. This exclusion doesn't apply for Insured Person having any health insurance indemnity policy in India at least for a period of 12/24/36/48 months as applicable, prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

ii. First 30 days waiting period

A waiting period of 30 days from the Inception Date of the Policy will be applicable for all hospitalisation claims except in case of accidents. This exclusion doesn't apply for Insured Person having any health insurance indemnity policy in India at least for a period of 30 days prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

iii. Two Year waiting periods

A waiting period of 24 months shall apply to the treatment, of the following, whether medical or surgical for all Medical Expenses along with their complications on treatment towards:

a. Cataract,
b. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
c. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis,

Joint Replacement Surgery (other than caused by Accident), Prolapse of Inter-vertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylitis, Spondylolisthesis, Congenital Internal,

d. Varicose Veins and Varicose Ulcers,
e. Stones in the urinary uro-genital and biliary systems including calculus diseases,
f. Benign Prostate Hypertrophy, all types of Hydrocele,
g. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Haemorrhoids and any abscess related to the anal region.
h. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
i. Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumour s/skin tumour s, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,
j. Any surgery of the genito-urinary system unless necessitated by malignancy.

If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing then they will have to be covered after the pre-exiting disease waiting period of (24/ 36/ 48 months) as per the plan opted.

iv. Maternity Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 48 months of continuous coverage has elapsed for that particular Insured Person since the inception of the first policy with us. However, this exclusion / waiting period will not apply to ectopic pregnancy proved by diagnostic means and certified to be life threatening by the attending medical practitioner.
Wherever Optional Cover for 'Reduction in Maternity Waiting Period' has been opted this limit will be reduced to 24 months of continuous cover.

v. Personal Waiting period:

A special waiting period not exceeding 48 months, may be applied to individual Insured persons for the list of acceptable Medical Ailments listed under Section V (vi). Underwriting Loading & Special Conditions, depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving your specific consent.

vi. 90 day waiting period for Critical Illness Add On Cover (if opted)

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

vii. 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. Stem cell implantation/surgery, harvesting, storage or any kind of treatment using stem cells.
2. Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalisation or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
3. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
4. Birth control procedures, contraceptive supplies or services including complications arising due to supplying services, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception, surrogate or vicarious pregnancy.
5. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, cochlear implants, vaccinations except post-bite treatment or for new born baby up to 90 days, any physical, psychiatric or psychological examinations or testing , any treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall treatment & products, issue of medical certificates and examinations as to suitability for employment or travel.
6. Laser Surgery for treatment of focal error correction other than for focal error of +/- 7 or more and is medically necessary.
7. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
8. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
9. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
10. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
11. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
12. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD)
13. Treatment for general debility, ageing, convalescence, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, ,run down condition or rest cure, congenital external anomalies or defects, sterility, fertility, infertility including IVF and other assisted conception procedures and its complications, subfertility, impotency, venereal disease, or intentional self-injury, suicide or attempted suicide(whether sane or insane).
14. Certification / Diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognised or experimental or unproven, or any form of clinical trials or any kind of self-medication and its complications.
15. Ailment requiring treatment due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation.
16. Any illness or hospitalisation arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.
17. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics.
18. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
19. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.

20. Any cosmetic surgery, aesthetic treatment unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity/ morbid obesity (unless certified to be life threatening) or treatment/surgery /complications/illness arising as a consequence thereof.
21. Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses.
22. Any robotic, remote surgery or treatment using cyber knife.
23. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital.
24. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
25. Any form of Non-Allopathic treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.
26. Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.
27. Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a passenger in a regular scheduled airline or air Charter Company.
28. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
29. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
30. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalised, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.
31. Non-Medical Expenses including RMO charges, surcharges, night charges, service charges levied by the hospital under whatever head, registration/admission charges. For complete list of Non-medical expenses, Please log on to our Website.
32. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.
33. We shall not be obliged to make any payment that is brought about as a consequence of deliberate failure to seek or follow medical advice, or to intentional delay to circumvent the policy term and condition

VII. How can I buy the Policy?

Step 1: The product brochure, policy benefits, exclusions and premium details must be thoroughly understood and discussed with Our advisor/ Company representative, before buying the policy.

Step 2: Once the benefits of the policy are understood, the Proposal Form must be filled, wherein details of the prospective Insured Persons including medical information must be provided as accurately as possible.

Step 3: The proposal form with the required documents have to be submitted along with the premium.

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured and Age band, we would arrange the medical check-up's at Our network of diagnostic centres.

Step 5: Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and associated documents will be sent to you.

We shall process the proposals with speed and efficiency and the decision on the proposal thereof, shall be communicated in writing to You within a reasonable period but not exceeding 15 days from the date of receipt of proposals or any requirements called for by Us.

Where a proposal deposit is refundable to a prospect under any circumstances, the same shall be refunded within 15 days from the date of underwriting decision on the proposal.

Upon assessment if there is any change in terms or premium is loaded then We will inform You about any revised terms through a counter offer letter. We will issue the Policy only once you accept the counter offer. Where You do not agree to the counter offer we will cancel your proposal and refund any premium collected.

VIII. What is the Claim Process?

a) Duties of the claimant

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy.
- You must follow the advice provided by a Medical Practitioner.
- You must upon Our request, submit Yourself 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.
- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

b) Claim Process

In case of an Illness or an injury please notify Us either at the call centre or in writing:
The following details are to be provided to Us at the time of intimation of Claim:

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by Us

For a Cashless Claim -

In case of planned hospitalisation - at least 3 days prior to the planned date of admission.
In case of Emergency Hospitalisation - within 48 hours of such admission.

Cashless facility is available only at Our Network Hospital. The latest/updated list of network of hospitals will be available on our website. You can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided Us with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by Us).

For a Reimbursement Claim -
The following claim documents should reach us not later than 15 days from the date of discharge from Hospital –

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

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 Hospitalisation due to insufficient Sum Insured or insufficient information to determine admissibility in which case You may be required to pay for the treatment and submit the Claim for reimbursement to Us which will be considered subject to the Policy Terms & Conditions.

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

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on our website as also provided to you along with the Policy documents. The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder/ Insured Person is required to check the applicable list of Network Hospital on Our's website. Wherever a TPA is used, the TPA will only work to facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

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IX. What are the Plans Benefit Details?

The policy is available under 5 Plans as detailed below:
ManipalCigna ProHealth Insurance (Plan Benefit Structure)

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief					
Your Coverage Details:	*Identify your Plan*	***Protect***	***Plus***	***Preferred***	***Premier***	Accumulate
Basic Cover This section lists the Basic benefits available on your plan	*Identify your Opted Sum Insured*	*₹2.5 Lacs* *₹3.5 Lacs* *₹4.5 Lacs* *₹5.5 Lacs* *₹7.5 Lacs* *₹10 Lacs* *₹15 Lacs* *₹20 Lacs* *₹25 Lacs* *₹30 Lacs* *₹50 Lacs*	*₹4.5 Lacs* *₹5.5 Lacs* *₹7.5 Lacs* *₹10 Lacs* *₹15 Lacs* *₹20 Lacs* *₹25 Lacs* *₹30 Lacs* *₹50 Lacs*	*₹15 Lacs* *₹30 Lacs* *₹50 Lacs*	*₹100 Lacs*	*₹5.5 Lacs* *₹7.5 Lacs* *₹10 Lacs* *₹15 Lacs* *₹20 Lacs* *₹25 Lacs* *₹30 Lacs* *₹50 Lacs*
	Inpatient Hospitalisation (When you are hospitalised)	For Sum Insured up to ₹5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹7.5 Lacs and Above - Covered up to **any Room Category except Suite** or higher category	Covered up to any Room Category except Suite or higher category			For Sum Insured ₹5.5 Lacs - Covered up to Single Private Room For Sum Insured ₹7.5 Lacs and Above - Covered up to **any Room Category except Suite** or higher category
	Pre - hospitalisation	Medical Expenses Covered up to 60 days before date of hospitalisation				
	Post - hospitalisation	Medical Expenses Covered up to 90 days post discharge from hospital	Medical Expenses Covered up to 180 days post discharge from hospital			Medical Expenses Covered up to 90 days post discharge from hospital
	Day Care Treatment	Covered up to the limit of Sum Insured opted				
	Domiciliary Treatment (Treatment at Home)	Covered up to the limit of Sum Insured opted				
	Ambulance Cover (Reimbursement of Ambulance Expenses)	Up to ₹2000 paid per hospitalisation event	Up to ₹3000 paid per hospitalisation event	Actual incurred expenses paid per hospitalisation event		Up to ₹2000 per hospitalisation event
	Donor Expenses (Hospitalisation Expenses of the donor providing the organ)	Covered up to full Sum Insured				
	Worldwide Emergency Cover (Outside India)	Covered up to full Sum Insured once in a Policy Year				
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for unrelated illnesses in addition to the Sum Insured opted				
	AYUSH Cover	Covered up to full Sum Insured				
	Health Maintenance Benefit (Treatment that does not require hospitalisation and can be carried out in an Out Patient Department)	Covered up to ₹500 Per Policy Year	Covered up to ₹2000 Per Policy Year	Covered up to ₹15000 Per Policy Year.		Option to choose from - ₹5000, ₹10000, ₹15000, ₹20000 Per Policy Year. Can also be used to pay for Co-pay or Deductible. Up to 50 % of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy
	Cumulative Bonus on Health Maintenance Benefit	NA	NA	NA		5% Cumulative Bonus on the unutilized Health Maintenance Benefit limit (HMB) available at the end of the Policy Year irrespective of whether a claim is made on the expiring policy.
	Maternity Expenses	Not Available	Covered upto ₹15,000 for normal delivery and ₹25,000 for C-Section per event, after a Waiting Period of 48 months	Covered upto ₹50,000 for normal delivery and ₹100,000 for C-Section per event, after a waiting Period of 48 months	Covered upto ₹100,000 for normal delivery and ₹200,000 for C-Section per event, after a waiting Period of 48 months	Not Available
	New Born Baby Expenses		Covered for the inpatient hospitalisation expenses of a new born up to the limit provided under Maternity Expenses			
	First Year Vaccinations		Covered as per national immunisation programme over and above Maternity Sum Insured			

Value Added Covers This section lists the additional value added benefits that are available along with your plan	Health Check-Up	Available once every 3rd Policy year to all insured persons who have completed 18 years of Age	Available each policy year(excluding the first year), to all insured persons who have completed 18 years of Age		Available once every 3rd Policy year to all insured persons who have completed 18 years of Age
	Expert Opinion on Critical illness (By a Specialist)	Available once during the Policy Year			
	Cumulative Bonus	A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.	A guaranteed 10% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured		A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured.
	Healthy Rewards	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used against payable premium (including Taxes) from 1st Renewal of the Policy. OR they can be redeemed for equivalent value of Health Maintenance Benefits any time during the policy OR as equivalent value while availing services through our Network Providers as defined in the policy.			
Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Hospital Daily Cash Benefit	₹1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹2000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹3000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year	₹1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year
	Deductible (Please select the Sum Insured and Deductible amount as you have opted on the Policy. Deductible is the amount beyond which a claim will be payable in the Policy)	₹1/2/3/4/5/7.5/10 Lacs	₹1/2/3/4/5/7.5/10 Lacs	*Not Available*	₹0.5,1/2/3/4/ 5/7.5/10 Lacs
	Waiver of Deductible	Available	Available	Not Available	Available
	Reduction in Maternity Waiting	Not Available	Maternity waiting period Reduced from 48 months to 24 months		Not Available
	Voluntary Co-pay (The cost sharing percentage that you have opted will apply on each claim.) If you have opted for a Deductible, Voluntary Co-payment does not apply	10% or 20% Voluntary Co-payment for each and every claim as opted		Not Available	10% or 20% voluntary co-payment for each and every claim as opted on the Policy
	Waiver of Mandatory Co-pay	Waiver of Mandatory co-payment of 20% for Insured Persons aged 65 years and above			
	Cumulative Bonus booster	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured		Not Available	A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured
Add on cover (Rider) This section lists the Add on cover available under your plan	Critical Illness	Lump sum payment of an additional 100% of Sum Insured Opted		Not Available	Lump sum payment of an additional 100% of Sum Insured Opted

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

Disclaimer: This is only a summary of the product features. The actual benefits available shall be described in the policy, and will be subject to the policy terms, conditions and exclusions. For more details on risk factors, terms and conditions read the sales brochure and speak to Your advisor before concluding a sale.

Prohibition of Rebates (under section 41 of Insurance Act, 1938)
No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurers. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation.

Your Health Relationship Manager Has The Answer
Be it claims assistance or guidance, contact your Health RM anytime. **1800-102-4462** **customercare@manipalcigna.com** **www.manipalcigna.com**

Corporate Office: ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063. IRDAI Registration No. 151