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MANIPALCIGNA PROHEALTH SELECT

(PROSPECTUS)

I. What are the Key Highlights of the Policy?

BASIC COVERS
- In patient Hospitalization
- Pre-hospitalization
- Day care Treatment
- Donor Expenses
- Pre-Hospitalization
- Domiciliary Treatment
- Restoration of Sum Insured
- Post-Hospitalization
- Ambulance Cover
- AYUSH Cover

VALUE ADDED COVERS
- Cumulative Bonus
- Healthy Rewards

ADD ON COVER
- ManipalCigna Critical Illness Add On Cover
- ManipalCigna Health 360

OPTIONAL COVERS
- Deductible
- Voluntary Co-pay (Only for ProHealth Select (A))
- Cumulative Bonus Booster
- Removal of Room Rent Limit
- Disease Specific Sub limits (Only for ProHealth Select (A))
- RE-ASSURANCE
- Health Check Up
- (Only for ProHealth Select (A))
- Worldwide Emergency Cover (Only for ProHealth Select (A))
- Health Maintenance Benefit (Only for ProHealth Select (A))

II. What are the Basic covers?

i) In-patient Hospitalization

a. We will indemnify Medical Expenses of an Insured Person in case of Medically Necessary Hospitalization arising from an Illness or Injury provided such Medically Necessary Hospitalization is for more than 24 consecutive hours. We will pay the below mentioned Medical Expenses upto the Sum Insured for:.

b. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to eligible Room Category or eligible Room Rent as per the Policy and specified in the Schedule to this Policy.

c. Intensive Care Unit charges for accommodation in ICU,

d. Operation theatre charges,

e. Fees of Medical Practitioner/ Surgeon,

f. Anaesthetist,

g. Qualified Nurses,

h. Specialists,

i. Cost of diagnostic tests,

I. Medicines,

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

We will indemnify the Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatment of the Insured Person subject to Illness/ Injury being covered under Hospitalization Expenses and the necessity being certified by an authorized Medical Practitioner.

The following Modern and Advanced Treatment methods will be indemnified (wherever medically indicated) when availed under In-patient Hospitalization or as a Day Care Treatment (Section II.4):

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy - Monoclonal Antibody to be given as injection

f. Intra vitreal injections

g. Stereotactic radio surgeries

h. Bronchial Thermoplasty

i. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)

j. IONM (Intra Operative Neuro Monitoring)

k. Stem cell therapy - Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Indemnification of Medical Expenses related to any admission (under In-patient Hospitalization, Day Care Treatment or Domiciliary Hospitalization) primarily for enteral feedings will be covered, up to 15 days in a Policy Year provided it is Medically Necessary and is prescribed by a Medical Practitioner.

We will indemnify the Medical Expenses incurred for the Medically Necessary Treatment, taken during In-patient Hospitalization of the Insured Person, from or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof or sexually transmitted diseases (STD). This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time.

If you choose a hospital room that is higher than your eligible room category, you will need to pay a proportionate share of the associated medical expenses. This will be calculated based on the difference between your eligible room rent and the actual room rent charged by the hospital.

The proportionate deduction will apply to “Associated Medical Expenses” shall include - Nursing Charges, Operation Theatre Charges, Fees of Medical Practitioner/Surgeon/ Anesthetist/ Specialist excluding cost of pharmacy

and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalization in ICU.

Associated Medical Expenses shall be applicable for covered expenses, incurred in Hospitals which follow differential billing based on the room category.

Understanding proportionate deduction with a simple example

Mr. Raj was hospitalized for **4 days** in a **Deluxe Room** at XYZ Hospital. However, as per his policy, he was eligible for the most economical **Single Private AC Room**.

Since he chose a higher room category than what his policy allowed, proportionate deduction will apply. This means the claim amount will be calculated based on the ratio between his eligible room rent and the actual room rent charged by the hospital.

Item	Details
Actual Room Rent Expense (Deluxe Room) [A]	₹10,000 per day * 4 days= ₹40,000
Eligible Room Rent expense (Single Private AC room) [B]	₹6,000 per day * 4 days = ₹24,000
Proportionate Ratio [B/A]	Eligible Room Rent ÷ Actual Room Rent = 6,000 ÷ 10,000 = **0.6**
Actual Associated Medical Expenses (AME) (includes Nursing charges, OT charges, consultation fees etc.) **[C]**	₹42,000
Eligible AME after Proportionate deduction [D]	₹25,200 (C*0.6)
Pharmacy & consumables, diagnostic tests, implants, medical devices ***(not subject to proportionate deduction)*** **[E]**	₹10,000
Total Bill Amount at actuals (F = A + C + E)	₹92,000
Amount Paid by Insurer after Proportionate deduction (G = B + D + E)	₹59,200
Amount Payable by Policyholder/Insured Person (F – G)	₹32,800

ii) Pre - hospitalization

We will reimburse, Pre-hospitalization Medical Expenses, upto the Sum Insured, incurred during the 60 days immediately prior to the date the Insured was admitted in the Hospital. This benefit is payable only if a claim has been admitted under ‘In-patient Hospitalization’ or “Day Care Treatment’ and is related to the same illness/injury and if the Pre-hospitalization Medical expenses are incurred during a Policy Year.

iii) Post - hospitalization

We will reimburse, Post-hospitalization Medical Expenses, upto the Sum Insured, incurred during the 180 days immediately post the date the Insured was discharged from the Hospital. This benefit is payable only if a claim has been admitted under ‘In-patient Hospitalization’ or “Day Care Treatment’

and expenses are related to the same illness/condition.

iv) Day Care Treatment

We will indemnify the Medical Expenses incurred for an Insured Person upto the Sum Insured in the event of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization due to advancement in medical technology. Such treatment must be undertaken in a Hospital, Nursing Home, or Day Care Centre.

Special Conditions :

a. The Day Care Treatment is Medically Necessary and undertaken based on the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for the procedure performed as Day Care Treatment.
c. Out-Patient (OPD) Treatment and diagnostic services are not covered under this benefit.
d. Coverage under this benefit shall also include pre-hospitalization and post hospitalization medical expenses, up to the limit specified in the Policy Schedule.
e. For list of Day Care treatments covered under this policy, please refer Annexure II of the policy.

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v) Domiciliary Treatment

We will reimburse Medical Expenses of an Insured Person, up to the Sum Insured, for an Illness or Injury which in the normal course would have required Hospitalization but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a Hospital transfer; or
ii. A Hospital bed is unavailable;

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

(a) We will however pay for Pre-Hospitalization and Post-Hospitalization Medical Expenses up to 30 days each in accordance with Section II.2 and D.I.3 above.

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

i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis,
cough and cold, Influenza,
ii. Arthritis, gout and rheumatism,
iii. Chronic nephritis and nephritic syndrome,
iv. Diarrhoea and all type of dysenteries, including gastroenteritis,
v. Diabetes mellitus and Insipidus,
vi. Epilepsy,
vii. Hypertension,
viii. Pyrexia of unknown origin.
ix. Any use of artificial life maintenance including life support machine use.

vi) Ambulance Cover

a. We will reimburse Reasonable and Customary expenses up to the amount specified in the Policy Schedule, towards transportation of an Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury in case of an Emergency, necessitating the Insured Person's admission to the Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

b.Reasonable and Customary expenses shall include:

i. To transport you from the incident site to the nearest hospital and/or

ii. To transport you from one hospital to another nearest hospital if the current hospital doesn't have the required medical treatment facility you need and/or

iii. To transport you from a hospital to a nearby diagnostic center and back, for diagnostic tests advised by your doctor, that aren't available at your current hospital

vii) Donor Expenses

a. We will cover In-patient Hospitalization Medical Expenses towards the donor (in accordance with Section D.I.1 above) for harvesting the organ up to the limits of the Sum Insured, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that -

b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advice.

c. We have admitted a claim under Section D.I.1 - towards In-patient Hospitalization

d. We will not cover expenses towards the Donor in respect of:

i. Any Pre or Post - hospitalization Medical Expenses,

ii. Cost towards donor screening,

iii. Cost directly or indirectly associated to the acquisition of the organ,

iv. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

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viii) Restoration of Sum Insured

We will provide for a 100% restoration of opted Base Sum Insured once in a Policy Year, provided that:

(a) The total of the opted Base Sum Insured and earned Cumulative Bonus (or Cumulative Bonus Booster if opted) is insufficient as a result of previous claims in that Policy Year.

(b) The Restored amount shall not be available for claims towards an Illness / Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person.

(c) The Restored amount will be available only for claims made by Insured Persons in respect of future claims that become payable under Section D.I of the Policy and shall not apply to the first claim in the Policy Year.

(d) The Restored amount will not be considered while calculating the Cumulative Bonus or Cumulative Bonus Booster (if opted).

(e) Such restoration of amount will be available only once during a Policy Year to each insured in case of an individual Policy and can be utilised by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

(f) If the Policy is issued on a floater basis, the Restored amount will also be available on a floater basis.

(g) If the Restored amount is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

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

i. The Base Sum Insured

ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)

(i) During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:

i. The Base Sum Insured

ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)

iii. Restored Sum Insured

(j) Restoration shall not apply to Worldwide Emergency Cover and for ₹0.5 & 1 Lac Sum Insured undeProHealth Select (A).

ix) AYUSH Cover

We will indemnify In-patient hospitalization/day care treatment expenses up to the limit of Sum Insured, for an Insured Person towards non- allopathic treatments such as Ayurveda, Yoga & Naturopathy, Unani, Sidha and Homeopathy for Hospitalization arising due to Accident or Illness provided such treatment is taken in a AYUSH Hospital.

The following exclusions will apply in addition to the exclusions under section V:

- Facilities & services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation etc.
- Any treatment outside India.

III. What are the Value Added Covers?

i) Cumulative Bonus

On completion of each Policy Year with Us, Insured Persons shall be granted Cumulative Bonus irrespective of any claims made during the expiring Policy Year

Special Conditions for Cumulative Bonus

a) A bonus of 5% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period.
b) No Cumulative Bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.
c) Bonus shall be provided irrespective of claims made in the expiring policy year
d) Any accumulated Cumulative bonus shall be carried forward to subsequent policy years.
e) Claims made during a policy year under Cumulative bonus shall reduce the balance bonus amount available for the remainder of such Policy Year.
f) Cumulative Bonus can be accumulated upto a maximum of 100% of your Base Sum Insured under the current Policy.
g) If the Policy Period is two/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.
h) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated 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 Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
i) 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 opted Base Sum Insured in to two or more Family Floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
j) If the opted Base Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the Base Sum Insured of the last completed Policy Year.
k) If the Base Sum Insured of the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Base Sum Insured of the last completed Policy year.

ii) Healthy Rewards

You can earn reward points equivalent to 1% of premium paid including taxes as applicable & 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. Each program can be opted once per Policy Year by a particular Insured Person.

There will be no limitation to the number of programs one can enrol for in a single Policy Period. However, the maximum earning of Healthy Rewards on a Policy will be limited to 10% of premium paid in that Policy Period.

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)	0.50%
Targeted Risk Assessment (TRA)	0.50%
Online Lifestyle Management Program (LMP)	1%
Chronic Condition Management Programs	1%
Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives	2%
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 -

- A discount in premium from 1st renewal of the Policy.
- As equivalent value while availing services through any of Our Network Providers as defined in the Policy.
- Equivalent value of Health Maintenance Benefit anytime during the Policy. (Applicable if HMB optional cover has been opted under ProHealth Select (A))

Details of Healthy Rewards earned on each Policy will be updated in our records against the policy as and when earned. Accrual for reward points will be the same for 1, 2 & 3 year policies.

Policyholder/Insured can approach Us for redemption anytime during the policy period. For availing a discount on renewal premium, the same will be available only at the time such renewal is due.

Any earned reward points will lapse at the end of the grace period if the policy is not renewed with us.

The notifications related to wellness programs will be communicated via SMS, email and the program specific phone / web application. Details about reward points will be available on program app or shared through SMS or renewal notice sent to customers.

IV. What are the Optional Covers?

The following Optional Covers shall be available under this Policy only if specifically opted for and indicated as active in the Policy Schedule. Once selected, the Optional Cover shall apply uniformly to all Insured Persons covered under the Policy and cannot be chosen on an individual basis.

i) Deductible

An Annual Aggregate Deductible is the amount you agree to pay on your own, once, each policy year before your policy starts paying for covered claims.
The deductible amount that you choose will be mentioned in your Policy Schedule. Once your total admissible medical expenses in a policy year exceed this amount, we start paying for admissible claims as per policy terms for that policy year.

Key Service Terms

1. **When you can choose it:** The deductible can be selected at the time of buying the policy or at renewal, and it applies to the entire policy on all or none basis.
2. **Changes at renewal:** You can increase, reduce, or remove the deductible only once at renewal, subject to underwriting approval.

a. If you reduce or remove the deductible, waiting periods will apply again on the reduced portion.
b. If you remove the deductible, you cannot choose this benefit again in future renewals

3. **Benefits where deductible does NOT apply:** You can claim the below benefits without exhausting the deductible:

    a. Healthy Rewards
    b. Health Check-Up
    c. Health-maintenance Benefit

d. Add-on/Riders

4. **Policy Terms Apply:** All other policy terms, conditions, waiting periods, and exclusions will continue to apply.
5. **Meeting the deductible & Claim Consideration:** This deductible will be calculated on an **annual aggregate basis**, considering only the claims made during the Policy Year, that are admissible under the policy terms and conditions and fall under the coverages listed below
   i. In-Patient Hospitalization
   ii. Pre-Hospitalization Medical Expenses
   iii. Post-Hospitalization Medical Expenses
   iv. Day Care Treatment
   v. Domiciliary Hospitalization
   vi. Ambulance Cover
   vii. Donor Expenses
   viii. AYUSH Treatment
   ix. Disease Specific Sub-limit

Claims will be paid only after you submit documents proving that the deductible has been exhausted. Expenses that are not admissible under the policy terms and conditions shall not be considered for meeting the deductible.

ii) Voluntary Co-pay (Applicable only for ProHealth Select (A))

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 indemnify 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-pays shall apply to all sections other than Add on Riders, Health Maintenance Benefit and Health Check Up benefits if opted.

Co-pay will be applied on the admissible claim amount.

iii) Cumulative Bonus Booster

The Policyholder can select from any one of the options below, and the applicable bonus benefit will be adjusted accordingly:

a) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 100% of Base Sum Insured.

b) A bonus of 25% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 100% of Base Sum Insured.

c) A bonus of 50% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 100% of Base Sum Insured.

d) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

<u>Special conditions applicable to Cumulative Bonus Booster</u>

a) When the Policyholder chooses the Cumulative Bonus Booster at renewal, any Cumulative Bonus already earned under this Policy will be carried forward. From that renewal onwards, the regular Cumulative Bonus under Section III.(1) will stop applying, and any future bonus accumulation will happen as per the terms of the Cumulative Bonus Booster benefit.

b) All clause applicable under Cumulative Bonus section III. (1) shall apply to this benefit as well.

iv) Removal of Room Rent Limit

We will provide for an option to remove the Room Rent limit applicable on the Inpatient Hospitalization and upgrade to a Single Private AC Room. All terms and conditions of Inpatient Hospitalization under Section II.(I). shall apply.

v) Re-Assurance

You may choose to opt for Re-Assurance under the policy. Under Re-Assurance, We will provide an automatic extension of Policy Renewal for a period of 2 (two) Policy Years from the date of expiry of the current policy, if during the Policy Period an Insured Person is diagnosed with any of the Critical Illnesses named below or suffers from Permanent Total Disability described below due to an Accident, provided that the Insured Person is not added in to the Policy mid-term and has attained 18 years of age at the inception of the Policy Year in which the event occurred.

This automatic extension will be available only once in the lifetime of an Insured Person, in respect of either a Critical Illness or a Permanent Total Disability Event which qualifies for coverage as per criteria specified under this Policy, irrespective of the sequence of its occurrence.

Reassurance can be availed by each Insured Person separately in case of an individual policy and once during the lifetime of a Policy in case of floater policies covering all Insured Persons under the Floater. Where this extension is triggered for a child attaining age 24 years during subsequent renewals, both the parent and split policy of the child will be eligible for this automatic extension.

Critical Illness covered

If an Insured Person is diagnosed to be suffering from a Critical Illness (as listed below) while the Policy is in force as a first incidence the Policy will automatically extend for a period of 2 Policy Years.

For the purpose of this Policy, Critical Illness shall mean any Illness, medical event or Surgical Procedure as specifically defined below whose signs or symptoms first commence at least 90 days after the Inception of Policy Period. If such Critical Illness is acquired as a result of a pre-existing condition then the standard waiting periods for pre-existing diseases shall apply.

1. Cancer of specified severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure Requiring Regular Dialysis
7. Stroke Resulting in Permanent Symptoms
8. Major Organ / Bone Marrow Transplant
9. Permanent Paralysis of Limbs
10. Motor Neuron Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms

Permanent Total Disability Covered

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, the Policy will automatically extend for a period of 2 Policy Years provided that the Policy is in force at the time of such event. Coverage for Permanent Total Disability due to Accident will start from day one.

1. Total and irrecoverable loss of sight of both eyes
2. Loss by physical separation or total and permanent loss of use of both hands or both feet
3. Loss by physical separation or total and permanent loss of use of one hand and one foot
4. Total and irrecoverable loss of sight of one eye and loss of a Limb
5. Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
6. Total and irrecoverable loss of hearing of both ears and loss of speech

7. Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye
8. Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever

Automatic Renewal shall apply only to the base cover including any Optional Covers, excluding any Add On Riders, on the same terms as per the expiring policy and any change in terms or coverage or addition of members at the time such renewal is due shall be subject to underwriting as per the standard renewal process and payment of any additional premium if any change is accepted by Us.

vi) Health Check Up (Applicable only for ProHealth Select (A))

We will provide for a Health Check-Up for each and every Insured Persons above the age of 18 years. 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.

Any claim under this benefit shall not impact Cumulative Bonus. Health Check-Ups will be available once each year.

ProHealth Select	Sum Insured	Age	List of tests
(A)	0.5, 1, 2, 3 Lacs	From 18 years onwards	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT
		18 to 40 years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT
(A)	4 ,5, 7, 10 Lacs	More than 40 years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT For females only - TSH
		18 to 40 years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT,CBC-ESR, Lipid Profile, SGOT, GGT
(A)	15, 20, 25 Lacs	More than 40 years (For males only)	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT
		More than 40 years (For females only)	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT,CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT

Full explanation of Tests is provided here:

MER – Medical Examination Report, FBS – Fasting Blood Sugar, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT – Test Serum Glutamic Pyruvate Transaminase, HbA1C – Glycosylated Haemoglobin Test, RUA – Routine Urine Analysis, SGOT – Serum Glutamic Oxaloacetic Transaminase, TSH – Thyroid Stimulating Hormone, TMT – Tread Mill Test, USG – Ultrasound Sonography, PSA – Prostate Specific Antigen, Pap smear - Papanicolaou test

vii) Worldwide Emergency Cover (Applicable only for ProHealth Select (A))

We will cover medical expenses incurred 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 and that are admissible under In Patient Hospitalization 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 hospitalization has been made to us within 48 hours of such admission.

The medical expenses payable shall be limited to Inpatient hospitalization and shall be made in India and in Indian Rupees on reimbursement basis. Cashless Facility may be arranged on a case-to-case basis. The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be

considered for conversion. 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 the 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.

viii) Disease Specific Sub-Limit (Applicable only for ProHealth Select (A))

You may choose to opt for Disease Specific Sub-Limit on an optional basis under ProHealth Select (A) The balance amount, if any, subject to the applicability of sub-limits on expenses on treatment of Named ailments/Procedures, our liability to make payment shall be limited to such extent as applicable.
Maximum payable per surgery or medical management cost per policy year.

		Sub-Limit (Amount in ₹)		
Ailments/ Surgeries / Medical Procedures		**Option 1**	**Option 2**	**Option 3**
1	Cataract (Per eye)	7,500	15,000	22,500
2	Surgeries for Non-malignant Tumors/Cysts/Nodule/ Polyp/Benign Prostate Hypertrophy	15,000	30,000	45,000
3	Stone in Urinary/Biliary System	20,000	40,000	60,000
4	Hernia (per side) 12,500 25,000	12,500	25,000	37,500
5	Appendicitis	10,000	20,000	30,000
6	Hysterectomy	15,000	30,000	45,000
7	Any Joint Replacement	40,000	60,000	80,000
8	Piles/Fissures/Fistula	10,000	20,000	30,000
9	Medical Management or Surgeries related to Ischemic Heart Disease/ Cardiac	40,000	60,000	80,000
10	Treatment for Injuries/Breakage of Bones	27,500	55,000	80,000
11	Cerebrovascular Medical Management/Surgery	25,000	50,000	75,000
12	Cancer/Oncology (Medical & Surgical)	40,000	60,000	80,000
13	Abscess/Ligament Tear	20,000	40,000	60,000
14	Treatment towards Kidney damage or renal failure	40,000	60,000	80,000

Wherever the above-mentioned sub-limits are applied, co-payment for the treatment taken at higher zone as mentioned under section V.(v)(4) shall also apply.

ix) Health Maintenance Benefit (Applicable only for ProHealth Select (A))

We will cover, only by way of reimbursement costs towards Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred on an Out Patient basis upto the amount specified under this benefit.

We will cover costs incurred towards:

- Diagnostic tests, preventive tests, drugs, prosthetics, medical aids, prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule.
- Towards Dental Treatments and Alternative Forms of Medicines wherever prescribed by a Medical Practitioner.

Any unused HMB limit at the end of a Policy Year shall lapse and will not be carried forward. A new HMB limit shall be reinstated at the commencement of each new Policy Year.

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x) Rider/Add On Benefit:

A. ManipalCigna Critical Illness Add on Cover

Along with this Policy, You can also avail the ManipalCigna Critical Illness Add on Cover. Please ask for the Proposal Form of the same at the time of purchase. All terms and conditions of the applicable rider including medical check-up requirements will apply.

B. ManipalCigna Health 360

Along with this Product You can also avail the ManipalCigna Health 360 (MCIHLIA23023V012223) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All terms and conditions of applicable rider including Health declaration wherever applicable will apply.

a. ManipalCigna Health 360-Shield:

Coverage for listed Non-medical items up to base policy Sum Insured and Durable Medical Equipment up to maximum of Rs.1 Lac.

b. ManipalCigna Health 360-OPD:

Package 1: Coverage for doctor consultations on cashless basis within the OPD Sum Insured.

Package 2: Coverage for doctor consultations and prescribed diagnostics on cashless basis within the OPD Sum Insured

Package 3: Coverage for doctor consultations, prescribed diagnostics and pharmacy on cashless basis within the OPD Sum Insured. Pharmacy limit is 20% of the OPD Sum Insured.

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 between 91 days to 5 years will be covered only if either of the parents is covered.
b. Children from 6 years to 18 years will only be covered if one of the parents is the proposer.
c. Children up to 23 years can be covered under the floater as dependents
d. Children beyond 23 years if dependent on the parents 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 policy 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 policy can cover self, lawfully wedded spouse, dependent children up to the age of 23 years or dependant parents. A floater cover can cover a maximum of 2 adults and 3 dependent 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) Sum Insured Options

You have the option to choose from a wide range of Sum Insured's available under different variants.

ProHealth Select	Sum Insured (Lacs)
(A)	0.5, 1, 2, 3, 4, 5, 7, 10, 15, 20, 25 Lacs
(B)	2, 3, 4, 5, 7, 10, 15, 20, 25 Lacs

v) Discounts under the Policy

You can avail of the following discounts on the premium.

1. Portfolio Discount (Only for ProHealth Select (A)):

a) Portfolio Gender Mix Discount: If the proportion of female members in an Affinity portfolio is 20% or more, then discounts will be applicable as per the following table:

Portfolio Gender Mix Discount	
Female Proportion	**Discount**
Proportion < 20%	0.0%
20% <= Proportion < 40%	2.5%
40% <= Proportion < 60%	5.0%
60% <= Proportion < 80%	7.5%
80% <= Proportion < 100%	10.0%

b) Portfolio Region Mix Discount: If the proportion of members in an Affinity portfolio outside of Zone 1 is 20% or more, then discounts will be applicable as per the following table:

Portfolio Gender Mix Discount		
Population Proportion	**Zone 2**	**Zone 3**
Proportion < 20%	0.0%	0.0%
20% <= Proportion < 40%	2.0%	4.0%
40% <= Proportion < 60%	4.0%	4.0%
60% <= Proportion < 80%	6.0%	12.0%
80% <= Proportion < 100%	8.0%	16.0%

Notes:

i. Zones are defined as under:

Zone 1: Mumbai, Thane, Navi Mumbai, Delhi and NCR

Zone 2: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Gujarat

Zone 3: Rest of India excluding locations mentioned under Zone 1 and Zone 2

ii. For a portfolio with exposure to only Zone 1 & Zone 2, discounts as per the Zone 2 column above will be available as per the proportion of the portfolio in Zone 2.

iii. For a portfolio with exposure to only Zone 1 & Zone 3, discounts as per the Zone 3 column above will be available as per the proportion of the portfolio in Zone 3.

iv. For a portfolio with exposure to Zone 1, Zone 2 & Zone 3, then the average of the discounts as per the Zone 2 & Zone 3 columns above will be available as per the total proportion of the portfolio in Zones 2 &3.

Portfolio discounts will be calculated at the portfolio level based on the base premium rates for the ProHealth Select (A) variant.

Applicable portfolio discount will apply on all policies offered to members of the Affinity portfolio.

The maximum Portfolio discount on offer for a single Affinity partner will be limited at 26%.

The premium for any of the optional benefits, such as Cumulative Bonus Booster, Room Rent Cap Waiver, Reassurance, Health Check-up, Worldwide Emergency Cover, Health Maintenance Benefit, will then be charged relative to the discounted premium rate for the base plan.

Any loading for Medical Underwriting at an individual policyholder level will be applicable on the discounted premium rate offered for the portfolio.

2. Family Discount: Discount offered is 10% for policies covering more than 2 individuals with individual Sum Insured.

3. **Long Term Discount:** Discount offered is 7.5% for policies with term 2 years and 10% for policies with term 3 years, only upon payment of lump sum premium. The discount is available only with Single Premium Payment Mode.

   Family and Long Term Discounts will be available for both ProHealth Select (A) and (B) variants. For the ProHealth Select (A) variant, these discounts will be over and above the 26% cap for Portfolio discounts.

4. **Zone Discount (Only for ProHealth Select (B)):** Discount offered is 8% for customer from Zone 2 and 16% for customer from Zone 3.

   Zone Classification

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

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

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

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

   (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 Hospitalization due to an Accident.

vi) Underwriting Loading & Special Conditions

We may apply a risk loading on the premium payable (excluding statutory levies & taxes as applicable) 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 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 or through an electronic mode, as the case may be and We will only issue the Policy once We receive your consent and applicable premium within the duration specified in the counter offer.

vii) Premiums

The Premium charged on the Policy will depend on the variant, Sum Insured, Policy Tenure, Age, Zone, Policy Type, Optional Covers, Premium Payment mode 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.

Premium can be paid on Single, Yearly, Half yearly, Quarterly and Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy. In case of premium payment modes other than Single and Yearly, a loading will be applied on the premium.

Loading grid applicable for Half yearly, Quarterly and Monthly payment mode

Premium payment mode	% Loading on premium
Monthly	5.50
Quarterly	3.50
Half yearly	2.50

The premium payment mode can be changed only on a policy anniversary by sending a request at least one month in advance. Change in premium payment mode is subject to:

a. Payment of premium and loading, if any.
b. Minimum premium requirement for the requested premium payment mode, if any.
c. Availability of the requested premium payment mode on the day of implementation of request.
d. Premium rates/ tables applicable for the changed premium payment mode will be the same as the premium rates/ tables applicable on the date of commencement of policy.

viii) Renewal of Policy

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

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

ix) Renewal Terms

i. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.
ii. In case the coverage under the Re-Assurance is triggered, Renewals will be effected accordingly for the immediate two Policy Years and customer will not require to pay any premium for such renewals, provided the terms and conditions of the contract are not altered. Post completion of the said period, all renewals shall be subject to standard renewal terms under this section.
iii. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-existing Condition.
iv. Where We have discontinued or withdrawn this product You will have the option to renew under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy.
v. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.
vi. We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are 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 45 days prior to date of such revision or modification.
vii. Alterations like increase/ decrease in Base Sum Insured or Change in Product, addition/deletion of members, addition/deletion of optional covers/riders, addition deletion of Medical Condition will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation

to acceptance of request for change of Sum Insured on renewal. The terms and conditions of the existing policy will not be altered.

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

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

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

xi. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the policy.

xii. 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.

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

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

ii. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.

iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

iv. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH/Standing Instruction facility.

v. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination of the policy.

x) Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer the proposed Insured Person will get the accrued continuity benefits to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc as per IRDAI Guidelines on portability.

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

The Free Look period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.The insured person shall be allowed a free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.

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

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

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

xiii) Cancellations

i. The policyholder may cancel this policy by giving 7 days written notice at any time during the term and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

A. Policy Tenure of 1 Year:

1. If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of the cancellation request will be considered as the expiry date of coverage.
2. If a claim has been made during the Policy period, no refund will be given to the Policyholder.

Illustration:

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

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

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

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

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

B. If Policy Tenure is more than 1 years:

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

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2025

Tenure (in Years)	2
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	650
Premium Refund	88.92 (100*650/731)

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

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non- disclosure of material facts, established fraud by the insured person subject to moratorium clause by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

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 in Policyholder
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not impact premium)
- 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
- Rectification in Gender of the Proposer/ Insured Person

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
- Addition of Member (New Born Baby or Newly Wedded Spouse)
- Change in Address (Resulting in Change in Zone under ProHealth Select (B)
- Change of occupation of the insured (if it changes the risk class of insured)
- 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)

Any other change requested during the Policy Period will be assessed by the underwriting team and if required additional information/documents may be requested. Sum Insured and Coverage changes will not be permitted during the mid-term.

xv) Redressal of Grievance

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

Email: customercare@manipalcigna.com,

Senior Citizens may write to us at - seniorcitizensupport@manipalcigna.com

Toll Free: 1800-102-4462

Contact No.: 022-61703600

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

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

'The Grievance Cell,

401/402, 4th Floor, Raheja Titanium,

Western Express Highway, Goregaon (East),

Mumbai - 400063, Maharashtra, India

or

Email - headcustomercare@manipalcigna.com.

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

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

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

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

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

xvi) Pre-Policy Medical Check-up

Pre-policy medical check-up may be required based on optional cover(s) chosen, Sum Insured, Age and/or any health declaration. Medical tests will be facilitated by Us and conducted at Our network of diagnostic centres. Full cost of all such tests will be borne by Us for all accepted proposals.

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 the cost for such tests.

xvii) Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured Person will get the accrued continuity benefits to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. as per IRDAI guidelines on migration.

xviii) Moratorium Period

After completion of 60 continuous months of coverage (including Portability and Migration) in health insurance policy, no Policy and claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of 60 continuous months is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of Sums Insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

xix) Revival of policy

If your Policy has passed the stipulated grace period due to non-payment of premium, you may be allowed for revival of your policy, subject to certain specific terms and conditions.

Specific conditions applicable to revival of policy

a. The policy could be revived maximum within 180 days from lapse of the first payment due date
b. Revival of policy shall be subject to our discretion and may require the below additional conditions (if deemed necessary by us):

1. Special conditions,
2. Assessment of current health status or Good health declaration
3. Undergoing medical examinations
4. Payment of all the premium (inclusive of applicable taxes) that was due and unpaid

c. Any claim/medical expense incurred during the lapsed period (time from when the grace period ends till the time payment is made) shall not be paid even after revival of policy i.e. no claim would be admissible for the break-in period in your policy.
d. If a 'Good Health Declaration' is sought by us and is later proven to be fraudulent, the entire policy shall be cancelled, and no claims shall be payable.
e. The Company reserves the right to accept or decline the revival of such lapsed policy and the continuation of coverage and benefits such as waiting period credits, accrued Bonuses and moratorium period protection is purely subject to Insurer's approval by way of issuance of the continued policy. In such an event, the coverage under the policy would re-commence from the date of company's decision of acceptance of revival of policy and subject to payment of all due premiums.

xx) Coverage Standards & Protocols

Medicine is an evidence-based science. Clinical diagnosis supported by positive investigation test findings are its founding principles. Treatment in Medicine are given as per well-defined protocols.

Our goal is to deliver care that is appropriate, effective, and safe. Equally important is avoiding treatments that are not medically necessary, as this helps safeguard patient well-being. Insurance, by design, is to support healthcare needs and not to change treatment choices. Furthermore, a key principle in insurance suggests that having coverage should not influence healthcare decisions. Patients naturally consider the benefits of treatment along with its cost and choose care that offers the best value and medical results. This approach supports responsible, value-based care that focuses on what is truly needed for recovery and long-term health.

A. Medical Protocols

We are committed towards supporting safe, effective, and evidence-based medical care. To help bring clarity and consistency, we will be referring to trusted and widely accepted sources such as leading medical textbooks, All India Institutes of Medical Sciences

(AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and National Institute for Health and Care Excellence (NICE).

These guidelines are designed to help explain:

a. When hospitalization is needed, including guidance on the appropriate level of care (for example: admission in an ICU or non-ICU room)

b. What treatments and procedures are considered appropriate, based on the medical condition and its severity, including recommended medicines and procedures

To ensure patient safety and quality of care, coverage under this policy shall be aligned with treatments and medicines that are approved by recognized regulatory authorities such as the Central Drugs Standard Control Organisation (CDSCO), Food and Drug administration (FDA), and other relevant bodies in India. Any treatment, medicine not approved by CDSCO, FDA and other appropriate authorities in India shall not be covered under the policy.

We also follow official guidance provided by manufacturers and regulatory authorities regarding how medicines and procedures should be used, including their approved indications and precautions. Treatments or medications used outside their approved purpose (often called “off-label” or extra usage) shall not be covered under the policy, as these fall outside established approval and safety guidelines.

Our approach is focused on transparency, safety, and supporting care that is medically appropriate and widely accepted, helping customers make informed healthcare decisions with confidence.

B. Position statements

Medicine is constantly evolving, wherein, new technologies and treatment approaches are emerging regularly. While many innovations offer promise, not all deliver outcomes that are meaningfully better when considered alongside their costs and established alternatives.

As a responsible insurer, we believe in being transparent and clear with our customers. Therefore, our decision on the coverage of illnesses or injury shall be basis texts and medical protocols published/recognised by globally trusted establishments like All India Institutes of Medical Sciences (AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and National Institute for Health and Care Excellence (NICE). Our evaluations will be based on comprehensive Health Technology Assessments, health economic evaluations, cost-benefit and cost-efficiency analyses, along with other well-regarded global research published in reputable medical journals. Any research found to have conflicts of interest will be excluded from consideration.

Medical protocols published by these establishments will outline how we assess different medicines, treatments, procedures, investigations, and therapies. Depending on the clinical and scientific evaluation, we may either cover the Reasonable and Customary charge incurred on a treatment wholly or partially or may recommend suitable alternatives or may seek additional review or in some cases may be unable to provide coverage under this product.

Importantly, if our medically-informed assessment results in no coverage or partial coverage for a particular treatment, we will still ensure payment at least up to the cost of the most widely accepted and commonly used alternative treatment currently available for that condition.

C. Prolonged Hospitalization extending beyond 10 days

a. It is important that you inform us in a timely manner. If we do not receive intimation within 10 days from the date of admission, we may apply an additional cumulative co-payment of 10% on the final admissible claim amount.

b. We may request for indoor case papers, treatment sheets, and daily monitoring records to help us understand and support the medical need for the extended stay.

c. If the medical records indicates that the insured’s health parameters have stabilized and yet the hospitalization continues, expenses related to the extended period of stay may not be payable under this

policy.

D. Organ Transplants

a. For live donor organ transplants, we kindly request that you inform us at least 7 days in advance, even if the hospitalization is planned at a non-network hospital. This allows us to assist you more effectively through the process.

b. In the case of a cadaveric organ transplant, where advance planning may not always be possible, please inform us as early as feasible, and no later than 48 hours from the date and time of admission, even if treatment is at a non-network hospital.

c. For all Kidney, liver and pancreas transplants, a biopsy of the recipient's organ may be required as part of the medical evaluation process.

d. If treatment is taken at a non-network hospital and we do not receive the required intimation or the biopsy report as outlined above, an additional 20% co-payment may be applicable on the admissible claim amount.

xxi) Utilization of Sum Insured

Sequence of utilization of Sum Insured will be as follows:

a. Base Sum Insured (if remaining for that claim)

b. Cumulative Bonus/Cumulative Bonus Booster (earned and remaining for that claim)

c. Restoration (if applicable for that claim)

xxii) Personal Data and Privacy

Personal and health data will be processed only for policy issuance, servicing and claims, and may include ABDM/ABHA-enabled services where consented; you can withdraw such consent at any time (see Policy T&C).

xxiii) Pre-Policy medical check up

Where a pre-policy medical check-up has been undertaken by the proposed Insured Person(s) and the insurance policy is not issued or the proposal is not taken forward, the entire expenses incurred towards the pre-policy medical check-up shall be payable by the Proposer.

xxiv) Indemnity principle clause

The total amount paid for the same admissible claim, whether under one or more indemnity covers or policies, with us or any other insurer, will not be more than the actual expenses incurred by the Insured Person

VI. What are the Waiting Period and Exclusions?

We will not pay for any claim caused by or related to the conditions listed below, unless it is specifically covered under a benefit in your policy

b. Waiting periods will apply separately to each insured person, and claims will be assessed accordingly.

c. The waiting periods and exclusions listed below will apply to all benefits (base and optional) under the policy, except for:

1. Healthy Rewards
2. Health Check-Up
3. ReAssurance

i. Pre-Existing Diseases - Code- Excl 01

ii. Specified disease/procedure waiting period- Code- Excl 02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured

increase.

c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures provided:

i. Cataract,

ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, any internal congenital anomalies, 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

iv. Varicose Veins and Varicose Ulcers,

v. Stones in the urinary uro-genital and biliary systems including calculus diseases,

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Haemorrhoids and any abscess related to the anal region.

viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.

ix. Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumour s/skin tumours, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,

x. 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 36 months.

iii. 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within opted period of continuous coverage from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

iv. 90 day waiting period for Critical Illness under Re-Assurance & Add On Cover (if opted)

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

v. Personal Waiting Period:

A special Waiting Period not exceeding 36 months may be applied to individual Insured Persons for the list of acceptable Medical Ailments listed under the Underwriting Manual of the Product, depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

vi. 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. Investigation & Evaluation- Code- Excl 04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care- Code- Excl 05

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.

b. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/ Weight Control: Code- Excl 06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- Uncontrolled Type^2 Diabetes

4. Change-of-Gender treatments: Code- Excl 07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are excluded, except for sex reassignment surgery for transgender persons.

5. Cosmetic or plastic Surgery: Code- Excl 08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner for reconstruction following an Accident, Burn(s) or Cancer.

6. Hazardous or Adventure sports: Code- Excl 09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. Breach of law: Code- Excl 10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. (e.g. Intentional self-Injury, suicide or attempted suicide (whether sane or insane).

8. Excluded Providers: Code- Excl 11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl 12)

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

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. (Code- Excl 14)

12. Refractive Error: Code- Excl 15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

13. Unproven Treatments: Code- Excl 16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility: Code- Excl 17

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

15. Maternity: Code Excl 18

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
b. Expense towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

16. External Congenital Anomaly or defects of any complications or conditions arising therefrom.

17. Dental treatment, orthodontic treatment ,dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours Hospitalization 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.

18. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

19. 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.

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

21. 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.

22. Treatment received outside the geographical limits of India other than for coverage under World Wide Emergency Cover.

23. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

24. Any deductible amount or percentage of admissible claim under co-pay or above Sub-Limit if applicable and as specified in the Schedule to this Policy.

25. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack or in any other sequence to the loss.

26. All expenses directly or indirectly, caused by or arising from war or war-like situation, or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

27. For complete list of non-medical items, please refer to the Annexure IV, List I of “Non-Payable Items” and also on Our website.

28. Any form of Non-Allopathic treatment (except AYUSH Cover), Hydrotherapy, Acupuncture, Reflexology or Chiropractic treatment.

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

30. Expenses related to cataract treatment involving all types of Multi-focal Lenses (including intraocular lenses), Multi-focal Toric Lenses, and Femto Laser-assisted surgeries are not covered.

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

32. Any kind of Out-Patient Treatment expenses including fractures (not requiring any kind of hospitalization)

33. Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

34. Stem cell harvesting

35. Vaccination including inoculation and immunisations (except post animal bite treatment)
36. Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.
37. Any treatment and associated expenses for alopecia, baldness including cortico steroids and topical immuno therapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.
38. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.
39. Drugs or treatments which are not supported by a prescription.
40. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.
41. Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre or AYUSH Hospital.
42. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.
43. Expenses incurred towards artificial life maintenance, including life support, after the patient has been certified to be in a vegetative state by the treating medical practitioner shall not be payable.

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.

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured, Age band or any medical declaration, we would arrange the medical check-ups 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.

In case we are unable to underwrite Your proposal We will intimate the same to You.

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

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 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 Hospitalization - at least 48 hours prior to the planned date of admission.

In case of Emergency Hospitalization - within 24 hours of such admission.

Cashless facility is available only at Our Network Hospital or Common empanelment of hospital / healthcare providers as specified by Insurance Council. 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 Investigations/ 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, wherever the case in under further investigation or available documents do not provide clarify.

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 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 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, 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 website. A TPA will be used for Network Access and facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

IX. What are the Benefit Details?

The policy is available under 2 variants as detailed below:

ProHealth Select (A) available to Affinity Partners (Corporate Agents)

ProHealth Select (B) available to Agency, Broking and Direct Channels

ProHealth Select	(A)	(B)
Sum Insured	₹0.5, 1, 2, 3, 4, 5, 7, 10, 15, 20, 25 Lacs	₹2, 3, 4, 5, 7, 10, 15, 20, 25 Lacs
Basic Covers		
In-patient Hospitalization	Covered up to Sum Insured Room Rent: Covered up to 2% of Base Sum Insured for a Hospital Room, up to a maximum of ₹3,000 ICU Charges: Up to 4% of Base Sum Insured for ICU up to a max of ₹7,000 This benefit shall offer the below covers up to the limits mentioned: **i)** Listed Modern and Advanced Treatment: up to Sum Insured **ii)** HIV/AIDS & STD: Up to Sum Insured	
Pre-Hospitalization	60 days	
Post Hospitalization	90 days	
Day-care Treatment	171 procedures, Covered up to full sum insured	
Domiciliary Treatment	Covered up to full sum Insured	
Ambulance Cover	Up to ₹2,000 per Hospitalization event	
Donor Expenses	Covered up to Sum Insured	
Restoration of Sum Insured	Available once in a policy year for unrelated illnesses in addition to the Sum Insured opted. Available for all Sum Insured's except ₹0.5L and 1L	
AYUSH Cover	Coverage for Ayurvedic, Yoga & Naturopathy, Unani, Siddha and Homeopathy up to the limit of Sum Insured	
Value Added Covers		

Cumulative Bonus	5% each year maximum up to 100%. This will not be reduced in case of claim under the Policy.	
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 to get a discount in premium from the next renewal OR they can be redeemed for availing services through any of Our network providers as defined in the policy OR Equivalent value of Health Maintenance Benefit anytime during the Policy. (Applicable if HMB optional cover has been opted under ProHealth Select (A))	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 to get a discount in premium from the next renewal OR they can be redeemed for availing services through any of Our network providers as defined in the policy.
Optional Covers		
Deductible*	1/2/3/4/5 Lacs in all combinations provided the Deductible is not higher than the Sum Insured opted.	1/2/3/4/5 Lacs in all combinations provided the Deductible is not higher than the Sum Insured opted.
Voluntary Co-pay*	10% or 20% voluntary co-payment for each and every claim as opted on the Policy	Not Available
Cumulative Bonus Booster (any one of the 4 choices)	a) 10% increase in Base Sum Insured, maximum up to 100%, irrespective of a claim under the Policy. b) 25% increase in Base Sum Insured, maximum up to 100%, irrespective of a claim under the Policy. c) 50% Increase in Base Sum Insured, maximum up to 100%, irrespective of a claim under the Policy. d) 10% increase in Base Sum Insured, maximum up to 200% irrespective of a claim under the Policy.	
Removal of Room Rent Limit	Covered up to Single Private AC Room	
Health Checkup	Every year for all Insured Persons above 18 years based on the applicable Grid.	Not Available
Re-Assurance	Automatic Extension of Policy for 2 years on diagnosis of a Critical Illness or Permanent Total Disability due to Accident	
Disease Specific Sub Limits	As per limits specified	Not Available
Health Maintenance Benefit	Covered up to ₹500 or 1000 as opted	Not Available
Worldwide Emergency Cover	Covered up to full Sum Insured once in a policy year	Not Available
Add On Cover	ManipalCigna Critical Add On Cover	
	ManipalCigna Health 360-Shield: Coverage for listed Non-medical items up to base policy Sum Insured and Durable Medical Equipment up to maximum of 1 Lac ManipalCigna Health 360-OPD Package 1: Coverage for doctor consultations on cashless basis within the OPD Sum Insured Package 2: Coverage for doctor consultations and prescribed diagnostics on cashless basis within the OPD Sum Insured Package 3: Coverage for doctor consultations, prescribed diagnostics and pharmacy on cashless basis within the OPD Sum Insured. Pharmacy limit is 20% of the OPD Sum Insure	

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

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 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 prospectuses 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

Annexures:

Illustration of Benefits

Rate Charts