**ManipalCigna Health Insurance Company Limited** (Formerly known as CignaTTK Health Insurance Company Limited)
**Corporate Office**: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com
**E-mail:** customercare@manipalcigna.com **CIN:** U66000MH2012PLC227948

ManipalCigna Health Insurance

# MANIPALCIGNA PROHEALTH SELECT PROSPECTUS

## I. What are the Key Highlights of the Policy?

**BASIC COVERS**

- In patient Hospitalisation
- Day care Treatment
- Donor Expenses
- Pre-Hospitalisation
- Domiciliary Treatment
- Restoration of Sum Insured
- Post-Hospitalisation
- Ambulance Cover
- AYUSH Cover

**VALUE ADDED COVERS**

- Cumulative Bonus
- Healthy Rewards

**ADD ON/RIDER COVER**

- Critical Illness Add On Cover

**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 Hospitalisation**

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

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

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

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain stimulation
- Oral chemotherapy
- Immunotherapy – Monoclonal Antibody to be given as injection
- Intra vitreal injections
- Stereotactic radio surgeries
- Bronchial Thermoplasty
- Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- IONM ( Intra Operative Neuro Monitoring)
- Stem cell therapy – Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Medical Expenses related to any admission (under In-patient hospitalisation, Day Care Treatment or Domiciliary hospitalisation) 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.

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

We will cover the Medical Expenses incurred towards Medically Necessary Treatment, taken during In-patient Hospitalisation of the Insured Person, arising out of a condition caused by or associated to 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).

The cover is available subject to below conditions:

i. The purpose of Hospitalisation is to avail Medically Necessary Treatment.
ii. The necessity of the Hospitalisation is certified by an authorised Medical Practitioner.
iii. For conditions other than STD, the Insured Person should be a declared HIV positive.
iv. This cover is available after a Waiting Period of 2 years from the inception of the Policy with Us, with respect to the Insured Person.
v. We will pay for Pre-hospitalisation and Post- hospitalisation medical expenses maximum up to 30 days each.

vi. Benefit under this cover is payable maximum up to the Sum Insured with a maximum limit of Rs. 5 Lacs and any claim under this section will reduce the Sum Insured.

In addition to the Policy exclusions, following additional exclusions shall be applicable:

a. Chronic health conditions including ischemic heart disease, chronic liver disease, chronic kidney disease, cerebro-vascular disease/ stroke, Chronic obstructive lung diseases, joint disorders and neoplasms which are not directly related to the patient's immunity status would not be covered under this benefit.

b. Lifestyle diseases like diabetes, hypertension, heart diseases and dyslipidaemia which are not related to HIV / AIDS or STD would not be covered under HIV/AIDS or STD limit.

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

For the purpose of this Section "Associated Medical Expenses" shall include - Room Rent, Nursing Charges, Operation Theatre Charges, Fees of Medical Practitioner/Surgeon/Anaesthetist/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 Hospitalisation in ICU.

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

**ii) Pre - hospitalisation**

We will reimburse medical expenses of an Insured person due to a disease or injury or illness incurred up to 60 days immediately prior to hospitalisation, by the Insured subject to a claim being admissible under In-patient Hospitalisation and expenses are related to the same illness/condition.

**iii) Post - hospitalisation**

We will reimburse medical expenses of an Insured person incurred up to 90 days immediately post hospitalisation due to a disease or injury or illness up to the limits specified under the Policy subject to a claim being admissible under In-patient Hospitalisation and expenses are related to the same illness/condition.

**iv) Day Care Treatment**

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

**v) Domiciliary Treatment**

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

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

**vi) Ambulance Cover**

We will cover the reasonable and customary expenses incurred for transportation of an Insured person by an ambulance service provider to the hospital for treatment following an emergency, requiring the Insured Person's admission to a Hospital. The coverage will be upto ₹ 2000 per Insured person per Hospitalisation event and necessity must be certified by the attending Medical Practitioner.

**vii) Donor Expenses**

We will cover in-patient hospitalisation medical expenses (in accordance with Section II.i above) towards the donor for harvesting the organ in case of major organ transplant if it is in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules. The organ donated is for the use of the Insured person per Medical Advice and a claim has been admitted under in patient hospitalisation.

However, Pre-Post hospitalisation expenses towards the donor, cost towards donor screening, cost directly or indirectly associated to the acquisition of the organ or any other medical treatment for the donor consequent on the harvesting will not be covered.

**viii) Restoration of Sum Insured**

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

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

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

a. The Sum Insured

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

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

a. The Sum Insured

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

c. Restored Sum Insured

Restoration of Sum Insured shall not apply to Worldwide Emergency Cover and for Rs 0.5 & 1 Lac Sum Insured under ProHealth Select (A).

**ix) AYUSH Cover**

We will cover In-patient medical 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 Hospitalisation arising due to Accident or Illness provided such Hospitalisation is for more than 24 hours and undertaken in a AYUSH, where an AYUSH Hospital is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:

i) Central or State Government AYUSH Hospital; or

ii) Teaching hospitals attached to AYUSH College recognized by Central Government / Central Council of Indian Medicine and Central Council of Homeopathy; or

iii) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

a) Having at least five in-patient beds;

b) Having qualified AYUSH Medical Practitioner in charge round the clock;

c) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

d) Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

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**

We will increase the opted Sum Insured by 5% at the end of the policy year if the policy is renewed with us provided that there are no claims paid or outstanding in the expiring Policy Year.

a. If the Policy is a Family Floater Policy, then the Cumulative Bonus will accrue only if no claims have been made in respect of any or all of the Insured Persons in the expiring Policy Year.

b. No cumulative bonus will be added if the policy is not renewed with us by the end of the grace period.

c. The cumulative bonus will not be accumulated in excess of 100% of the opted Sum Insured under the current policy with us under any circumstances.

d. Any earned Cumulative Bonus will not be reduced for claims made in the future unless utilised.

e. Wherever the earned cumulative bonus is used for payment of a claim during a particular policy year, the balance cumulative bonus if any will be carried forward to the next policy year.

f. If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.

g. 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.

h. 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 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.

i. If the opted Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

j. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

k. The Cumulative Bonus is provisional and is subject to revision if a Claim is made in respect of the expiring Policy Year, which is notified after the acceptance of renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.

l. This clause does not alter Our right to decline a renewal or cancellation of the Policy for reasons as mentioned under the

Cancellation clause of the Policy.

**ii) Healthy Rewards**

You can earn reward points equivalent to 1% of premium paid including taxes & levies for each Policy. In addition to this You can accumulate rewards by opting for an array of Our wellness programs listed below, that will help You to assess Your health status and aid in improving Your overall well-being. 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.

## IV. What are the Optional Covers?

The Policy can be extended to include the following optional covers by paying applicable additional premium. Wherever opted, such Optional Covers shall apply to all Insured Persons under a single policy without any individual selection.

i) **Deductible**

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

The deductible options: ₹1 Lac, ₹2 Lacs, ₹3 Lacs, ₹4 Lacs, ₹5 Lacs will be available upto Sum Insured of ₹25 Lacs in all combinations provided that deductible amount is not higher than the Sum Insured Opted.

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

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

**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 pay 90% or 80% of any amount that we assess (payable amount) for the payment or reimbursement in respect of any claim under the policy made by that Insured person and the balance will be borne by the Insured person.

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

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

**iii) Cumulative Bonus Booster**

You may choose one of the 4 Cumulative Bonus Options under the Policy as follows:

**Option a)** We will increase the opted Sum Insured by 10% at the end of the Policy Year, up to a maximum of 100%, if the policy is Renewed with Us provided that there are no claims paid or outstanding in the expiring Policy Year.

In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III.(I) shall not be available, however all terms and conditions of the said section shall apply.

**Option b)** We will increase the opted Sum Insured by 25% at the end of the Policy Year, up to a maximum of 100%, if the policy is Renewed with Us provided that there are no claims paid or outstanding in the expiring Policy Year.

In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III.(I) shall not be available, however all terms and conditions of the said section shall apply.

**Option c)** We will increase in the opted Sum Insured by 50% for each claim free year up to a maximum of 100%, when there are no claims paid or outstanding in the expiring Policy Year. In case of a claim being paid or remaining outstanding at the end of a Policy Year or at the time of Renewal of such Policy, the earned cumulative bonus will reduce by 50% in the subsequent year. However

this does not impact the opted Sum Insured.

In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III.(I) shall not be available, however all terms and conditions except III(i).d.e. of the said section shall apply.

**Option d)** We will increase in the opted Sum Insured by 10% at the end of each Policy Year irrespective of a claim under the expiring Policy Year, up to a maximum of 200%.

In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III.(I) shall not be available, however all terms and conditions except III(i).a.c. of the said section shall apply.

**iv) Removal of Room Rent Limit**

We will provide for an option to remove the Room Rent limit applicable on the Inpatient Hospitalisation and allow for coverage up to a Single Private Room. All terms and conditions of Inpatient Hospitalisation 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 |
| (A) | 4 ,5, 7, 10 Lacs | 18 to 40 years | Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT |
| | | More than 40 years | Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT For females only - TSH |
| (A) | 15, 20, 25 Lacs | 18 to 40 years | Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT |
| | | 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 Hospitalisation cover as per the terms of the Policy.

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

The medical expenses payable shall be limited to Inpatient hospitalisation and shall be made in India and in Indian Rupees on reimbursement basis. Cashless Facility may be arranged on a case to case basis. Insured person can contact Us at the numbers provided on the Health Card for any claim assistance. In case where Cumulative Bonus accumulated is used for payment of claim under 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 period

| 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 | 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 |

**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 unutilised HMB limit shall lapse at the end of the Policy Year and fresh limits will be available under the new Policy Year.

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

## V. What are Features of the Policy?

**i) Eligibility**

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

Coverage for children:

a. Children 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% | 8.0% |
| 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 the City of the proposed Insured Persons.

(a) Persons paying Zone I premium can avail treatment all over India without any co-pay.

(b) Persons paying Zone II premium

i) Can avail treatment in Zone II and Zone III without any co-pay.

ii) Availing treatment in Zone I will have to bear 10% of each and every claim.

(c) Person paying Zone III premium

i) Can avail treatment in Zone III, without any co-pay

ii) Availing treatment in Zone II will have to bear 10% of each and every claim.

iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

***Option to select a Zone higher or lower than that of the actual Zone is available on payment of relevant premium at the time of buying the policy or at the time of renewal. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

**vi) Underwriting Loading & Special Conditions**

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levies & taxes) based on your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience. Maximum Risk Loading per individual shall not exceed 100% of Premium excluding Statutory Levies and Taxes.

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 additional premium(if any) within the duration specified in the counter offer.

In case, You neither accept the counter offer nor revert to Us within the specified duration, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

**Additional Sub-limit applied on Special Conditions:** The Policy will pay only 75% of the payable claim amount arising out of the specified illness/medical condition as listed above and its complications as declared by the Insured Person or diagnosed at the time of pre-acceptance medical tests. Payable claim amount will be calculated after all the co-pays applicable under the Policy have been accounted. This condition will be applicable for a maximum of 48 months from the date of inception of first policy.

Details of applicable loadings by ailments/ medical test results are listed as below.

| Sr. No. | List of Acceptable Medical Ailments(subject to other co-existing conditions, age, duration of ailment and whether treatment is ongoing or completed) | Applicable Underwriting Loading Percentage on Premium |
|---|---|---|
| 1 | Anal fistula | 5 |
| 2 | Anemia, Hemolytic | 10 |
| 3 | Asthma | 10 |

| | | |
|---|---|---|
| 4 | Benign Prostatic Hyperplasia | 10 |
| 5 | Biliary stones | 10 |
| 6 | Cataract (if surgery not done) | 7.5 |
| 7 | Cholelithiasis | 10 |
| 8 | Deviated Nasal Septum | 7.5 |
| 9 | Diabetes Mellitus | 15 |
| 10 | Dyslipidemia | 7.5 |
| 11 | Epilepsy | 15 |
| 12 | Fatty Liver | 5 |
| 13 | Fibro adenoma breast (non-malignant) | 5 |
| 14 | Fissure in Ano | 5 |
| 15 | GERD (Gastric Esophageal Reflux Disease) | 10 |
| 16 | Hematuria | 10 |
| 17 | Hemorrhoids | 7.5 |
| 18 | Hydrocele | 10 |
| 19 | Hypertension | 15 |
| 20 | Inguinal Hernia | 7.5 |
| 21 | Leiomyoma of GI tract | 15 |
| 22 | Myoma Uterine | 10 |
| 23 | Nasal polyp | 7.5 |
| 24 | Ovarian Cysts | 5 |
| 25 | Peptic Ulcer Diseases | 7.5 |
| 26 | Poliomyelitis | 10 |
| 27 | Polycystic Ovarian Disease (PCOD) | 10 |
| 28 | Renal stones | 7.5 |
| 29 | Tuberculosis | 10 |
| 30 | Tympanoplasty | 5 |
| 31 | Umbilical hernia | 7.5 |
| 32 | Undescended Testicle | 5 |
| 33 | Urinary Tract infection (UTI) / kidney infection | 15 |
| 34 | Varicocele | 10 |
| 35 | Varicose Veins | 15 |
| 36 | Vertigo | 15 |

| S.No. | Medical Test | Range of Loading Percent (For more than 10 percentile deviation from normal test values) |
|---|---|---|
| 1 | Haemogram | 10 |
| 2 | Blood Sugar | 10 |
| 3 | Urine routine | 10 |
| 4 | Kidney Function Test | 10 |
| 5 | Complete Lipid Profile | 10 |
| 6 | Liver Function Test | 10 |
| 7 | Carcino Embryonic Antigen | In case of deviation from normal values, proposal will be declined. |
| 8 | Prostate Specific Antigen | In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis. |
| 9 | Thyroid Profile | 10 |
| 10 | C Reactive Protein | 10 |
| 11 | Tread Mill Test | In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis. |
| 12 | USG Abdomen & Pelvis | In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis. |
| 13 | X-Ray Chest | In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis. |
| 14 | HIV | In case of deviation from normal values, proposal will be declined. |
| 15 | Hepatitis B Surface Antigen | In case of deviation from normal values, proposal will be declined. |
| 16 | Pap Smear | In case of deviation from normal values, proposal will be declined. |
| 17 | 2D Echo | In case of deviation from normal values, medical test to be clinically correlated and evaluated on a case to case basis. |

Normal Test Values will be as per the medical test reports provided in the reports.

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 |

If we receive any amount in excess of the required premium, we will refund the excess without paying any interest on the excess amount. If we receive any amount lesser than the required premium, the same shall not be adjusted towards the premium and no interest shall be paid on the amount. You will not be entitled to any benefits or claims under the policy unless you pay the full premiums in time.

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)**

**i. Renewal of Policy**

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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 30/15, 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

**ii. 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 Hospitalisation 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 which has been approved by IRDAI.

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 approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

vii. Alterations like increase/ decrease in Sum Insured or Change in Product, addition/deletion of members, 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 changes on renewal. The terms and conditions of the existing policy will not be altered.

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

ix. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 48 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.

**iii. 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.

**ix) 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 45 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 in waiting periods as per IRDAI Guidelines on portability.

For Detailed Guidelines on Portability, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020 and Schedule I of IRDAI (Health Insurance) Regulations 2016 for the Portability norms.

**x) 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).

**xi) 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 fifteen 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. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or;

c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

**xii) Cancellations**

i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

<table>
<tr><th></th><th colspan="3">Refund</th></tr>
<tr><th>In force Period-Up to</th><th>1 Year</th><th>2 Year</th><th>3 Year</th></tr>
<tr><td>0 - 30 Days</td><td>75.00%</td><td>85.00%</td><td>90.00%</td></tr>
<tr><td>31 - 90 Days</td><td>50.00%</td><td>75.00%</td><td>85.00%</td></tr>
<tr><td>91 - 180 Days</td><td>25.00%</td><td>60.00%</td><td>75.00%</td></tr>
<tr><td>181 - 365 Days</td><td rowspan="6">NIL</td><td>50.00%</td><td>60.00%</td></tr>
<tr><td>366 - 455 Days</td><td>30.00%</td><td>50.00%</td></tr>
<tr><td>456 - 545 Days</td><td>20.00%</td><td>35.00%</td></tr>
<tr><td>546 - 730 Days</td><td rowspan="3">NIL</td><td>30.00%</td></tr>
<tr><td>731 - 910 Days</td><td>15.00%</td></tr>
<tr><td>More than 910 Days</td><td>NIL</td></tr>
</table>

The above grid is applicable to policies issued with Premium Payment mode 'Single' or 'Yearly (with Policy Tenure 1 Year)'. For 'Yearly' premium payment mode with Policy Tenure 2/3 years, premium shall be refunded basis above grid for 'Policy Year- 1'.

No refund will be processed for cancellation of policies with Premium Payment Mode as Half-yearly, Quarterly or Monthly.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non- disclosure of material facts, fraud by the insured person 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.

**xiii) 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
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer
- 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)

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.

**xiv) Redressal of Grievance**

In case of any grievance, the Insured Person may contact the Company through:

Website: www.manipalcigna.com

Toll Free : 1800-102-4462

Email: customercare@manipalcigna.com

Contact No : + 91 22 61703600

Post/Courier: Any of Our Branch office or Corporate office at the addresses available on Our website.

Insured Person may also approach the grievance cell at any of the Company's branches. If the Insured Person is not satisfied with the redressal of grievance through one of the above methods then Insured Person may contact the Grievance Officer at the Grievance Cell, ManipalCigna Health Insurance, ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited), 401/402, Raheja Titanium, Western Express Highway, Goregaon East, Mumbai - 400063. IRDAI Registration No. 151 or email headcustomercare@manipalcigna.com

If Insured Person is still not satisfied with the redressal of grievance through above methods, the Insured Person may 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 the Ombudsman offices are provided on Our Website.

**xv) Pre-Policy Medical Check-up**

We will require You to undergo a medical check-up based on Your age and the Sum Insured opted as provided in the grid below. Wherever any pre-existing disease or any other adverse medical history is declared , We may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age/ Sum Insured opted. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You Wherever required we may request for additional tests to be conducted based on the declarations in the proposal form and the results of any medical tests that you have undergone. Full cost of all such tests will be borne by us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer we will bear 50% of the cost for such tests.

| Prohealth Select | Sum Insured (Lacs) | Age Group (years) | Medical Tests | |
|---|---|---|---|---|
| (B) | 2, 3, 4 ,5, 7, 10 Lacs | Up to 45 years | NO TEST | |
| | | 46 to 55 years | Tests shall be based on Medical declarations by the Insured and underwriting evaluation. | |
| | | More than 55 years | SET 14 | MER, CBC, HbA1c, ECG, Sr Cholesterol, LDL, SGOT, SGPT, Serum Creatinine, Uric acid, |
| | 15, 20, 25 Lacs | Up to 50 years | Tests shall be based on Medical declarations by the Insured and underwriting evaluation | |
| | | More than 50 years | SET 4 | MER, CBC-ESR, USG A&P, HbA1c, FBS, TMT, Lipid Profile, SGOT, SGPT, GGT, Serum Creatinine, Uric acid, Routine Urine Analysis, CEA, HIV |

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

| | | | | |
|---|---|---|---|---|
| (A) | 0.50, 1, 2, 3, 4, 5, 7, 10 Lacs | Up to 45 years | NO TEST | |
| | | 46 to 65 years | Tests shall be based on Medical declarations by the Insured and underwriting evaluation. | |
| | | More than 65 years | SET 4 | MER, CBC-ESR, USG A&P, HbA1c, FBS, TMT, Lipid Profile, SGOT, SGPT, GGT, Serum Creatinine, Uric acid, Routine Urine Analysis, CEA, HIV |
| | Sum Insured 15,20,25 Lacs | Up to 18 years | NO TEST | |
| | | 19 to 55 years | Tests shall be based on Medical declarations by the Insured and underwriting evaluation | |
| | | More than 55 years | SET 4 | MER, CBC-ESR, USG A&P, HbA1c, FBS, TMT, Lipid Profile, SGOT, SGPT, GGT, Serum Creatinine, Uric acid, Routine Urine Analysis, CEA, HIV |

**Full explanation of Tests is provided here:** MER – Medical Examination Report, FBS – Fasting Blood Sugar, CEA – Carcino Embryonic Antigen, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, CBC - PS – Complete Blood Count - Peripheral Smear, SGPT –Serum Glutamic Pyruvate Transaminase, HbA1C – Glycosylated Haemoglobin Test, HIV- Human Immunodeficiency Virus, SGOT – Serum Glutamic Oxaloacetic Transaminase, TMT – Tread Mill Test, HBsAg – Hepatitis B Surface Antigen, LFT – Liver Function Test, RFT – Renal Functional Test, PSA – Prostate Specific Antigen, Pap Smear - Papanicolaou test, USG A & P: Ultrasonography Abdomen and Pelvis

**xvi) Migration**

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020.

**xvii) Moratorium Period**

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

## VI. What are the Waiting Period and Exclusions?

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

**i. Pre-Existing Diseases - Code- Excl 01**

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.

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

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

**ii. 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.

**iii. 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:

   a. Cataract,

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

c. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, 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

d. Varicose Veins and Varicose Ulcers,

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

f. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

j. Any surgery of the genito-urinary system unless necessitated by malignancy.

If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing then they will have to be covered after the pre-exiting disease waiting period of 48 months.

**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. 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.

**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 hospitalisation 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 hospitalisation) 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 any complications or conditions arising therefrom.

**17.** Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalisation or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.

**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 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 Alternative Treatment, except Inpatient for AYUSH.

**29.** Existing diseases disclosed by the Insured Person (limited to the extent of the ICD Codes mentioned in line with Chapter IV, Guidelines on Standardization of Exclusions in Health Insurance Contracts, 2019), provided the same is applied at the underwriting and consented by You/ Insured Person.

## 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 in person or over telecom/ or through the details available on our Website, before buying the policy.

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

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

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

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

In case we are unable to underwrite Your proposal We will intimate the same to You and refund any premium that has been collected.

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

## VIII. What is the Claim Process?

**a) Duties of the claimant**

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy
- You must follow the advice provided by a Medical Practitioner. We shall not be obliged to make any payment that is brought about as a consequence of failure to follow such advice.
- You must upon Our request, submit Yourself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.
- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

**b) Claim Process**

In case of an Illness or an injury please notify Us either at the call centre or in writing:

The following details are to be provided to Us at the time of intimation of Claim:

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

For a Cashless Claim -

In case of planned hospitalisation - at least 3 days prior to the planned date of admission.

In case of Emergency Hospitalisation - within 48 hours of such admission.

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

For a Reimbursement Claim -

The following claim documents should reach us not later than 15 days from the date of discharge from Hospital –

- Claim Form Duly Signed
- Original pre-authorisation request
- Copy of pre-authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes(if any)
- Original Hospital Main Bill and break up Bill
- Original Investigation Reports, X Ray, MRI, CT Films, HPE
- Doctors Reference Slips for 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 Hospitalisation due to insufficient Sum Insured or insufficient information to determine admissibility in which case You may be required to pay for the treatment and submit the Claim for reimbursement to Us which will be considered subject to the Policy Terms &Conditions.

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

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner, 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.

## VIII. 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 Hospitalisation | Covered up to 2% of Sum Insured for a Hospital Room, up to a max of ₹3,000<br>OR<br>Up to 4% of Sum Insured for ICU up to a max of ₹ 7,000 | |
| Pre-Hospitalisation | 60 days | |
| Post hospitalisation | 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 hospitalisation 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 Sum Insured, maximum up to 100%. This will not reduce in case of a claim under the Policy.<br>b) 25% increase in Sum Insured, maximum up to 100%. This will not reduce in case of a claim under the Policy.<br>c) 50% Increase in Sum Insured, maximum up to 100%. This will reduce by 50% in case of claim under the Policy, but in no case shall the Sum Insured be reduced.<br>d) 10% increase in Sum Insured, maximum up to 200% irrespective of a claim under the Policy. | |
| Removal of Room Rent Limit | Covered up to Single Private 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 | Critical Illness Add On Cover | |

* 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