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CIGNA TTK PROHEALTH INSURANCE POLICY PROSPECTUS

I. What are the Key Highlights of the Policy?

BASIC COVERS

- In patient Hospitalization
- Pre-hospitalization
- Post-hospitalization
- Day care Treatment
- Domiciliary Treatment
- Ambulance Cover
- Donor Expenses
- Worldwide Emergency Cover
- Restoration of Sum Insured
- Health Maintenance Benefit
- Maternity Expenses
- New Born Baby Expenses
- First Year Vaccinations

VALUE ADDED COVERS

- Health Check Up
- Expert opinion on Critical Illness
- Cumulative Bonus
- Healthy Rewards

OPTIONAL COVERS

- Deductible
- Reduction in Maternity Waiting
- Voluntary Co-pay

ADD ON COVER

- Critical Illness

II. What are the Basic covers?

i) In-patient Hospitalisation

We will cover medical expenses in case of medically necessary hospitalization of an Insured person incurred due to illness, accident 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 under the Plan opted, charges for accommodation in Intensive Care Unit and operation theatre charges, fees of medical practitioner, anaesthetist, qualified nurses, specialists, the cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending medical practitioner that are used intra operatively during a surgical procedure.

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

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 and Diagnostic Tests conducted within the same Hospital where the Insured Person has been admitted.

ii) Pre - hospitalisation

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

iii) Post - hospitalisation

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

iv) Day Care Treatment

We will cover payment of medical expenses of an Insured Person in case of medically necessary day care treatment or surgery that requires less than 24 hour s 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.

v) Domiciliary Treatment

We will cover medical expenses of an Insured person for treatment of an illness, accident 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-hospitalization expenses up to 30 days shall be payable, however, post-hospitalisation medical expenses shall not be payable. We shall not be liable under this policy for any claim in connection with or in respect of the following:

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- 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,
- Diabetes mellitus and insipidus,
- Hypertension,
- Diarrhoea and all type of dysenteries, including gastroenteritis,
- Epilepsy,
- Psychiatric or psychosomatic disorders of all kinds,
- Pyrexia of unknown origin.

vi) Ambulance Cover

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

vii) Donor Expenses

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

However, Pre-Post hospitalization 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) Worldwide Emergency Cover

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 up to limits specified under the plan opted by the Insured and 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 hospitalisation 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.

ix) Restoration of Sum Insured

In case the Sum Insured inclusive of earned cumulative bonus (if any) 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. Restoration of Sum Insured will be applicable only This restored amount can be used for all future claims not related to the illness/disease/injury for which a claim has been made in the particular policy year for the same Insured Person. Restoration will not trigger on the first claim.

In case the Restored Sum Insured is not utilised in a policy year, it shall not be carried forward to subsequent policy year. Any restored Sum Insured will not be used to calculate the Cumulative Bonus. 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. No Claims Bonus

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. No Claims Bonus

c. Restored Sum Insured

x) Health Maintenance Benefit

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.

We will cover costs incurred towards:

- Diagnostic 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.

All Waiting Periods and Permanent Exclusions shall not apply to this section.

xi) Maternity Expenses

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

The Insured person should have been continuously covered under this policy for at least 48 months before availing this benefit, except in case of opting for 'Reduction in maternity waiting' where the limit will be relaxed to 24 months of waiting.

Maternity Sum Insured will be limited to per event and in addition to Sum Insured opted under the Policy, however any restored amount will not be available for coverage under this section.

The following expenses are not covered under maternity benefit:

a. Medical expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.

b. Medical expenses for ectopic pregnancy. However, these expenses will be covered under the inpatient hospitalisation.

xii) New Born Baby Expenses

We cover medical expenses towards treatment of the Insured person's new born baby while the Insured Person is hospitalised as an in-patient for delivery, subject to a valid claim being accepted under maternity expenses.

This would include in-patient hospitalisation expenses incurred on the new born baby during and post birth including any complications up to a period of 90 days from the date of birth and within the limits specified under Maternity Expenses cover under the plan opted by You.

We would cover the baby beyond 90 days on payment of requisite premium subject to addition of the baby into the policy by way of an endorsement or at the next renewal whichever is earlier.

xiii) First Year Vaccinations

We will cover vaccination expenses of the new born baby as per National Immunization Scheme (India), until the new born baby completes one year (i.e.12 months). The coverage will be subject to claims admitted under maternity expenses cover and will be in addition to the Maternity Sum Insured available under the Plan. However maximum liability under the policy shall not exceed the opted Sum Insured. Any restored Sum Insured will not be available for coverage under this section.

If the policy ends before the new born baby has completed one year, then, such vaccinations shall be covered until the baby completes 12 months.

The vaccinations will be covered as per below schedule:

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

III. What are the Value Added Covers?

i) Health Check Up

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

For Protect plan - Health Check up's are available once every 3rd Policy year

For Plus, Preferred and Premier Plan - Health Check up's are available at each renewal

Plan Name	Sum Insured	Age	List of tests
Protect	₹ 2.5 Lacs, ₹ 3.5 Lacs, ₹ 4.5 Lacs,	>18 years	MER, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, Urine Routine, SGPT
Plus	₹ 4.5 Lacs, ₹ 5.5 Lacs,	18 to 40 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid
	₹ 7.5 Lacs, ₹ 10 Lacs	≥ 41 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid For females only - TSH, Pap smear, Mammogram For Males- PSA

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Plan Name	Sum Insured	Age	List of tests
Preferred & Premier	₹ 15 Lacs, ₹ 30 Lacs, ₹ 50 Lacs,	18 to 40 years	MER, Lipid Profile, HbA1c, Sr. Creatinine, CBC-ESR, RUA, SGPT, ECG, SGOT, GGT, Uric Acid For females: Pap smear, TSH, Mammogram For males: PSA
	₹ 100 Lacs	≥ 41 years (For males only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric acid, TMT, USG Abdomen & Pelvis, PSA
		≥ 41 years (For females only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, TMT, Uric acid, USG Abdomen & Pelvis, Pap smear, Mammogram, TSH

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

ii) Expert Opinion on Critical Illnesses

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

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

Covered Critical Illnesses shall include:

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

iii) Cumulative Bonus

We will increase the Sum Insured as per the plan opted, 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:

- No cumulative bonus will be added if the policy is not renewed with us by the end of the grace period. The cumulative bonus will not be accumulated in excess of 50% of the sum insured under the first policy with us.
- Any earned Cumulative Bonus will not be reduced for claims made in the future. Wherever the earned cumulative bonus is used for payment of a claim during a particular policy year, the balance cumulative bonus if any will be carried forward to the next policy year.
- Cumulative bonus shall not be available for claims made for maternity expenses, new born baby cover, first year vaccination and Worldwide Emergency Cover.

iv) Healthy Rewards

You can earn reward points equivalent to 1% of premium paid for each Policy. In addition to this You can accumulate rewards by opting for Our online 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 by a particular Insured Person and a maximum of 5 such online programmes can be availed to earn rewards during a Policy year. Details of reward points that can be accrued as per your plan opted is listed below -

Online Program	Points to be earned under Protect Plan	Points to be earned under Plus Plan	Points to be earned under Preferred Plan	Points to be earned under Premier Plan
Health Risk Assessment (HRA)	25	40	80	120
Targeted Risk Assessment (TRA)	50	80	160	240
Online Lifestyle Management Program (LMP)	50	80	160	240

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 the 3rd Annual Premium
- Equivalent value of Health Maintenance Benefit from 3rd Policy Year.

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IV. What are the Optional Covers?

i) Deductible

We provide an option of selecting deductible for ₹1, 2 or 3 Lacs on a Sum Insured's under Protect and Plus Plans. Wherever a Deductible option is selected, such deductible amount will be applied on each policy year on the aggregate of all admissible claims in that policy year.

The deductible options under Protect and Plus plans are listed below -

	Sum Insured	Deductible Options
PROTECT PLAN	₹ 3.5 Lac	₹ 1 Lac
	₹ 4.5 Lacs	₹ 1 Lac/ 2 Lac

	Sum Insured	Deductible Options
PLUS PLAN	₹ 4.5 Lac	₹ 1 Lac/ 2 Lac
	₹ 5.5 Lac	₹ 2 Lac/ 3 Lac
	₹ 7.5 Lac	₹ 2 Lac/ 3 Lac
	₹ 10 Lac	₹ 3 Lac

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

ii) Reduction in Maternity Waiting

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

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

iii) Voluntary Co-pay

Irrespective of the age and number of claims made by the Insured person and subject to the co-payment option chosen by you, it is agreed that we will only pay 90% or 80% of any amount that we assess 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 not apply to Critical Illness Add On (if opted), Health Check Up's.

V. What are the Add On Covers Available?

i) Critical Illness Add On Cover (Optional)

On payment of appropriate additional premium You can choose to cover the listed Critical Illnesses under the Policy. This Add On Cover will be available for all Insured Persons under a single policy without any individual selection.

Entry Age Limit for Add On Cover: 18 to 65 years
Renewal: Lifetime

We will provide a lump-sum critical illness benefit amount equivalent to the Sum Insured opted under the policy to the Insured person, on the first diagnosis of the covered critical illness. A waiting period of 90 days from the date of issuance of first policy shall apply for claiming under this benefit.

Covered Critical Illnesses:

1. Cancer of specified severity
2. First heart attack - of specified 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 neurone disease with permanent symptoms
11. Multiple sclerosis with persisting symptoms

a. Critical illness benefit is applicable for all persons who are aged above 18 years and can be availed once in the lifetime of an Insured person. For persons in the age group of 18 to 23 years who are covered as "Child" will not be eligible for benefit under this cover.

b. The benefit will be paid only if the Insured person survives for at least 30 days following the diagnosis of critical illness.

c. The benefit under this cover shall lapse once a claim for critical illness has been paid for that particular Insured person. However, lifetime renewal will be available for the underlying base cover of the policy including other optional covers wherever opted and renewal premiums will be adjusted accordingly.

d. All other eligible members can avail of this benefit during the same policy year or in subsequent renewals of the policy.

In case of a floater policy, We will provide for a 100% reinstatement of Sum Insured once during the lifetime of the Policy for the other adult Insured Person in the Policy.

"Reinstatement of Sum Insured" for the purpose of this Policy means the amount reinstated in accordance with the terms and conditions as stated above under this Policy.

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VI. 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 plan can be bought for self, lawfully wedded spouse, children, parents, siblings, parent in laws, grandparents and grandchildren.

b. In case of a floater cover, one family will share a single sum insured as opted. A floater plan can cover self, lawfully wedded spouse, 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 or two continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the date of issuance of the policy.

iv) Plan & Sum Insured Options

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

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

v) Discounts under the Policy

You can avail of the following discounts on the premium on Your policy.

a. Family Discount - of 10% for covering more than 2 family members under the same policy under the individual policy option.

b. Long Term Policy Discount - of 7.5% for selecting a 2 year policy.

c. Direct Policy Discount - of 10% if You buy this policy from Us directly without any intermediary.

d. Social Media Discount - If You choose to share Your online purchase of ProHealth Insurance Policy with Your friends on social media through the web, We will provide You with a discount of 2.5%

e. Worksite Marketing Discount - A discount of up to 10% will be available on polices which are sourced through worksite marketing channel. This discount and Direct Policy discount are mutually exclusive.

f. Co-pay Discount - A discount of 7.5% for opting 10% Co-pay and a discount of 15% for opting a 20% Co-pay on the Policy.

vi) Underwriting Loading & Special Conditions

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levis & taxes) based on your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). 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. Details of applicable loadings by ailments/ medical test results are listed as below along with the applicable sub-limits and waiting periods.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent and applicable additional premium.

Following loadings may be applied on the policy for the medical conditions listed below if they are accepted at the time of underwriting. The loadings are applicable on individual ailments only. Maximum Risk Loading per individual shall not exceed 100% of Premium excluding Statutory Levis and Taxes.

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S.No.	List of Acceptable Medical Ailments (subject to other co-existing conditions)	Applicable Underwriting Loading (In Percentage)
1	Anal fistula	10
2	Anemia, Hemolytic	10
3	Asthma	15
4	Benign Prostatic Hyperplasia	10
5	Biliary stones	10
6	Cataract (if surgery not done)	10
7	Cholelithiasis	10
8	Deviated Nasal Septum	10
9	Diabetes Mellitus	20
10	Dyslipidemia	15
11	Epilepsy	15
12	Fatty Liver	10
13	Fibroadenoma breast (non-malignant)	15
14	Fissure in Ano	10
15	GERD (Gastric Esophageal Reflux Disease)	15
16	Hematuria	10
17	Hemorrhoids	10
18	Hydrocele	10
19	Hypertension	20
20	Inguinal Hernia	10
21	Leiomyoma of GI tract	15
22	Myoma Uterine	10
23	Nasal polyp	10
24	Ovarian Cysts	15
25	Peptic Ulcer Diseases	10
26	Poliomyelitis	10
27	Polycystic Ovarian Disease (PCOD)	15
28	Renal stones	10
29	Tuberculosis	15
30	Tympanoplasty	10
31	Umbilical hernia	10
32	Undescended Testicle	15
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. If deviation is accepted then loading will be 20

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S.No.	Medical Test	Range of Loading Percent (For more than 10 percentile deviation from normal test values)
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. If deviation is accepted then loading will be 20
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. If deviation is accepted then loading will be 20
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. If deviation is accepted then loading will be 20
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. If deviation is accepted then loading will be 20

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

Personal Waiting Periods for Ailments declared or Diagnosed at the time of Pre-acceptance Medical Tests:

Personal Waiting Periods: Applicable Plan Wise

Range of Waiting Period (in yrs) Applicable for Pre Existing Disease for Pro Health Plan				
S.No.	List of Acceptable Medical Ailments	Protect Plan	Plus Plan	Preferred/ Premier Plan
1	Asthma	NA	4	4
2	Benign Prostatic Hyperplasia	NA	4	3
3	Biliary stones	NA	4	3
4	Cataract	NA	4	3
5	Cholelithiasis	NA	4	3
6	Diabetes Mellitus	NA	4	4
7	Epilepsy	NA	4	4
8	Fibroadenoma breast	NA	4	3
9	Fissure in Ano	NA	4	4
10	GERD (Gastric Esophageal Reflux Disease)	NA	4	4
11	Hemorrhoids	NA	4	4
12	Hypertension	NA	4	4
13	Inguinal Hernia	NA	4	3
14	Leiomyoma of GI tract	NA	4	4
15	Myoma Uterine	NA	4	3
16	Ovarian Cysts	NA	4	3
17	Peptic Ulcer Diseases	NA	4	4
18	Polycystic Ovarian Disease (PCOD)	NA	4	4
19	Renal stones	NA	4	3
20	Tuberculosis	NA	4	3
21	Umbilical hernia	NA	4	3
22	Undescended Testicle	NA	4	4
23	Urinary Tract infection (UTI) / kidney infection	NA	4	4
24	Varicose Veins	NA	4	3
25	Vertigo	NA	4	3

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Additional Sub-limit applied on Special Conditions: The Policy will pay only 75% of the Admissible claim amount arising out of the specified illness/medical condition and its complications as declared by the Insured Person or diagnosed at the time of pre-acceptance medical tests. Admissible claim amount will be calculated after apply all the co-pays applicable under the Policy have been accounted.

vii) Premiums

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

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

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

Zone Classification

Zone I: Mumbai, Thane & Navi Mumbai 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 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.

viii) Mandatory Co-pay

A compulsory co-payment of 20% is applicable on all claims for Insured Persons aged 65 years and above irrespective of the age of entry in to the Policy. Co-pay will be applied on the admissible claim amount.

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

ix) Renewal Features

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

b. The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous policy expiry date and current Policy start date. We however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-existing Condition.

c. Renewals will not be denied except on grounds of misrepresentation, fraud, non-disclosure or non-co-operation by You.

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

e. 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

f. We may in Our sole discretion, revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDA and in accordance with the IRDA rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claim s experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

g. Alterations like increase/ decrease in Sum Insured or Change in Plan/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.

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h. 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.

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

j. 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.1 to V.5 will be applicable considering such Policy Year as the first year of Policy with the Company.

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

l. Once an Insured Person attain age of 65 years on renewal a compulsory co-payment of 20% will be applicable on all claims irrespective of the age of entry in to the Policy.

m. 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 floater cover.

x) Portability Option

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

- You have been covered under an Indian retail health insurance policy from a Non-life Insurance company registered with IRDA without any break
- We should have received your application for portability with complete documentation at least 45 days before the expiry of your present period of Insurance
- If the Sum Insured under the previous policy is higher than the sum insured chosen under this policy, the applicable waiting periods under the Policy shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the Eligible Cumulative Bonus under the expiring health insurance policy.
- In case the proposed Sum Insured opted for under our policy is more than the insurance cover under the previous policy, then all applicable waiting periods under the Policy shall be applicable afresh to the amount by which the Sum Insured under this Policy exceed the total of Sum Insured and Eligible Cumulative Bonus under the expiring health insurance policy;
- All waiting periods under the Policy shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
- If You were covered on a floater basis under the expiring Policy and apply for a floater cover under this Policy, then the Eligible Cumulative Bonus to be carried forward on this Policy shall also be available on a floater basis.
- If You were covered on an individual basis in the expiring policy then the eligible Cumulative Bonus to be carried forward on this Policy shall be available on an individual basis.

For the purpose of this provision, Eligible Cumulative Bonus shall mean the Cumulative Bonus which You or the Insured Person would have been eligible for had the same policy been renewed with the existing insurance company.

The Portability provisions will be available to You, if you wish to migrate from this Policy to any other health insurance policy on renewals.

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

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

You have the option of returning the policy stating the reasons for cancellation and we shall refund the full premium on the policy. Cancellation will be allowed only if there are no claims reported (paid/outstanding) under the policy. All rights under this policy shall immediately stand extinguished on the free look cancellation of the policy.

xiii) Cancellations

In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 15 days' notice in writing.

Premium shall be refunded as per table below if no claim has been registered/ made under the policy and full premium has been received.

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1 Year		2 year	
Policy in force up to	**Premium Refund %**	**Policy in force up to**	**Premium Refund %**
1 Month	75%	1 Month	87.5%
3 months	50%	3 months	75%
6 months	25%	6 months	62.5%
More than 6 months	NIL	12 months	50%
		15 months	37.50%
		18 months	25%
		Above 18 months	NIL

xiv) Contribution

If two of more policies are taken by You during the same period from one or more Insurers to indemnify treatment costs and the amount of claim is within the Sum Insured limit of any of the policies, You will have the right to opt for a full settlement of Your claim in terms of any of your policies.

Where the amount to be claimed exceeds the Sum Insured under a single policy after considering deductibles, co-pays (if applicable), You can choose the insurer with which you would like to settle the claim. Wherever We receive such claims We have the right to apply the contribution clause while settling the claim.

xv) Subrogation

In case where We have settled a claim and subsequently you receive any amount towards settlement of the same claim, in the form of compensation or any other form, we reserve the first right to recover the settled amount such amount(s) received by You. This clause does not apply to benefit sections.

xvi) 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.

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

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

b) Financial Endorsements - which result in alteration in premium

- Deletion of Insured Member on Death or Separation or Policyholder/Insured Person Leaving the Country only if no claims are paid / outstanding.
- Change in Age/Date Of Birth
- Addition of Member (New Born Baby or Newly Wedded Spouse)
- Change in Address (resulting in change in Zone)
- Rectification in Gender of the Proposer/ Insured Person

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

xvii) Grievance Redressal

In case of a grievance , You can contact Us with the details through:

Our website: www.cignattkinsurance.in

Email: customercare@cignattk.in

Toll Free : 1-800-10-24462

Fax: 022 40825222

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

You can also walk-in and approach the grievance cell at any of Our branches. If in case You are not satisfied with the response then You can contact Our Head of Customer Service at the following email headcustomercare@cignattk.in

If You are still not satisfied with Our redressal, You may approach the nearest Insurance Ombudsman. The Contact details of the Ombudsman offices are provided on Our Website.

VII. What are the Waiting Period and Exclusions?

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

i. Pre-existing Disease waiting Period

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

ii. First 30 days waiting period

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

iii. Two Year waiting periods

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

b. Cataract,

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

d. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Inter-vertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylitis, Spondylolisthesis,

e. Varicose Veins and Varicose Ulcers,

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

g. Benign Prostate Hypertrophy, all types of Hydrocele, Congenital internal anomaly,

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

i. 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.

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

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

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

iv. Maternity Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 48 months of continuous coverage has elapsed for that particular Insured Person since the inception of the first policy with us. However, this exclusion / waiting period will not apply to ectopic pregnancy proved by diagnostic means and certified to be life threatening by the attending medical practitioner.

Wherever Optional Cover for 'Reduction in Maternity Waiting Period' has been opted this limit will be reduced to 24 months of continuous cover.

v. Personal Waiting period:

A special waiting period not exceeding 48 months, may be applied to individual Insured persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

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

Any critical illness contracted and/or 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.

vii. Permanent Exclusions

We shall not be liable to make any payment under this policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. Genetic disorder and stem cell implantation/surgery, harvesting, storage or any kind of treatment using stem cells.
2. Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours 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.
3. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
4. Birth control procedures, contraceptive supplies or services including complications arising due to supplying services, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception, surrogate or vicarious pregnancy.
5. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, cochlear implants, vaccinations except post-bite treatment or for new born baby up to 90 days, any physical, psychiatric or psychological examinations or testing , any treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall treatment & products, issue of medical certificates and examinations as to suitability for employment or travel.
6. Laser Surgery for treatment of focal error correction other than for focal error of +/- 7 or more and is medically necessary.
7. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
8. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
9. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
10. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
11. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
12. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD)
13. Treatment for general debility, ageing, convalescence, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, ,run down condition or rest cure, congenital external anomalies or defects, sterility, fertility, infertility including IVF and other assisted conception procedures and its complications, subfertility, impotency, venereal disease, puberty, menopause or intentional self-injury, suicide or attempted suicide(whether sane or insane).
14. Certification / Diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven, or any form of clinical trials or any kind of self-medication and its complications.
15. Ailment requiring treatment due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation.
16. Any illness or hospitalization arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.
17. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
18. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
19. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.
20. Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganization of personality or mind, or emotions or behaviour, including stress, Parkinsons or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition").
21. Any cosmetic surgery, aesthetic treatment unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity/morbid obesity (unless certified to be life threatening) or treatment/surgery /complications/illness arising as a consequence thereof.
22. Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses.
23. Any robotic, remote surgery or treatment using cyber knife.
24. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital.
25. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
26. Any form of Non-Allopathic treatment, Naturopathy, hydrotherapy, Ayurvedic, Homeopathy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

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27. Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.

28. Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular scheduled airline or air Charter Company.

29. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

30. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.

31. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.

32. Non-Medical Expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the hospital under whatever head, registration/admission charges. For complete list of Non-medical expenses, Please log on to our Website.

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

34. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

VIII. How can I buy the policy?

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

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

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

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

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

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.

Pre-Policy Medical Check-up

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

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

Plan Name	Sum Insured (Lacs)	Age Group (years)	Medical Tests
Protect Plan	2.5L, 3.5L, 4.5L	Up to 45	NO TEST
		46 - 55	SET 2 - MER, ECG, Total Cholesterol, HbA1c, Serum Creatinine, CBC-ESR, Routine Urine Analysis, SGPT
		> 55	SET 3 - MER, CBC-ESR, HbA1c, ECG, Lipid Profile, SGOT, SGPT, GGT, Serum Creatinine, Uric acid, Routine Urine Analysis
Plus Plan	4.5L, 5.5L, 7.5L	Up to 45	NO TEST
		46 - 55	SET 2 - MER, ECG, Total Cholesterol, HbA1c, Serum Creatinine, CBC-ESR, Routine Urine Analysis, SGPT
		> 55	SET 3 - MER, CBC-ESR, HbA1c, ECG, Lipid Profile, SGOT, SGPT, GGT, Serum Creatinine, Uric acid, Routine Urine Analysis

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Plus Plan	10L	Up to 40	NO TEST
		41 - 55	SET 3 - MER, CBC-ESR, HbA1c, ECG, Lipid Profile, SGOT, SGPT, GGT, Serum Creatinine, Uric acid, Routine Urine Analysis
		> 55	SET 5 - MER, CBC-PS, USG A&P, X-ray Chest, HbA1c, FBS, TMT, Lipid Profile, LFT, RFT, Routine Urine Analysis, CEA, HIV, PSA, Pap smear
Preferred Plan	15L , 30L, 50L	Up to 18	Set 1 - MER- Basic
		19 - 45	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
		> 45	SET 5 - MER, CBC-PS, USG A&P, X-ray Chest, HbA1c, FBS, TMT, Lipid Profile, LFT, RFT, Routine Urine Analysis, CEA, HIV, PSA, Pap smear
Premier Plan	100L	Up to 18	SET 1 - MER- Basic
		19 - 45	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
		> 45	SET 5 - MER, CBC-PS, USG A&P, X-ray Chest, HbA1c, FBS, TMT, Lipid Profile, LFT, RFT, Routine Urine Analysis, CEA, HIV, PSA, Pap Smear

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

Full explanation of Tests is provided here: MER - Medical Examination Report, FBS - Fasting Blood Sugar, 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

IX 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

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For a Cashless Claim -

In case of planned hospitalization - at least 7 days prior to the planned date of admission.

In case of Emergency Hospitalization - within 48 hour s of such admission.

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

For a Reimbursement Claim -

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

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

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

There can be instances where We may deny Cashless facility for 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 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's website.

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X. What are the Plans Benefit Details?

The policy is available under 4 Plans:

Cigna TTK ProHealth Insurance Policy Plan- Benefit Structure

		Protect	Plus	Preferred	Premier
Basic Covers	Sum Insured	₹ 2.5 Lac, ₹ 3.5 Lac, ₹ 4.5 Lac	₹ 4.5 Lac, ₹ 5.5 Lac, ₹ 7.5 Lac, ₹ 10 Lac	₹ 15 Lac, ₹ 30 Lac, ₹ 50 Lac,	₹ 100 Lac
	In-patient Hospitalization	Covered up to Shared room	Covered up to Single Private room	Covered up to Single Private room	Covered up to Single Private room
	Pre - Hospitalization	Covered up to 60 days before date of hospitalisation			
	Post - Hospitalization	Covered up to 90 days post discharge from hospital	Covered up to 180 days post discharge from hospital		
	Day Care Treatment	Covered up to full Sum Insured			
	Domiciliary Treatment	Covered up to full Sum Insured			
	Ambulance Cover	Up to ₹ 2000 per hospitalization event	Up to ₹ 3000 per hospitalization event	Actual expenses paid per hospitalization event	
	Donor Expenses	Covered upto full Sum Insured			
	Worldwide Emergency Cover	Covered upto full Sum Insured (once in a policy year)		Covered upto a maximum of ₹10 Lacs	
	Restoration Of Sum Insured	Available once in a policy year for unrelated illnesses in addition to the Sum Insured opted			Not Available
	Health Maintenance Benefit	Covered up to ₹ 500	Covered up to ₹ 2000	Covered upto ₹15000 per policy year	
	Maternity Expenses	Not Available	Covered upto ₹ 15,000 for normal delivery & ₹ 25,000 for C- Section per event After a Waiting Period of 48 months	Covered upto ₹ 50,000 for normal delivery and ₹ 100,000 for C-Section per event after a waiting Period of 48 months	
	New Born Baby Expenses	Not Available	Covered upto Limit under Maternity Expenses		
	First Year Vaccinations	Not Available	Covered as per national immunization programme over and above Maternity Expenses		
Value added covers	Health Check-Up	Available once every 3rd Policy year to all insured persons who have completed 18 years of Age	Available at each renewal, to all insured persons who have completed 18 years of Age		
	Expert Opinion on Critical illness	Available once during the Policy Year			
	Cumulative Bonus	5% Increase in Sum Insured, maximum upto 50%.	10% Increase in Sum Insured, maximum upto 50%		Not Available
	Healthy Rewards	Reward Points to be earned for each year of premium paid and accumulated for 2 years. Rewards can also be earned for enrolling and completing Our Online Wellness Programs. These earned Reward Points can be used to get a discount in premium from the 3rd Annual Premium OR they can be redeemed for equivalent value of Health Maintenance Benefits.			
Optional covers	Deductible*	Deductible Options for Protect Plan	Deductible Options for Plus Plan	Not Available	Not available
		₹ 2.5 Lac – NA	₹ 4.5 Lac – ₹ 1 Lac		
		₹ 3.5 Lac – 1 Lac	– ₹ 2 Lac		
		₹ 4.5 Lac – 1 Lac	₹ 5.5 Lac – ₹ 2 Lac		
		– 2 Lac	– ₹ 3 Lac		
		–	₹ 7.5 Lac – ₹ 2 Lac		
		–	– ₹ 3 Lac		
		–	₹ 10 Lac – ₹ 3 Lac		
	Reduction in Maternity Waiting	Not Available	Maternity waiting period Reduced to 24 months		
	Voluntary Co-Payment*	10% or 20% voluntary co-payment for each and every claim as opted on the Policy		Not Available	Not Available
Add on cover	Critical Illness	Lump sum payment of 100% of Basic Sum Insured Opted			Not Available

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

Disclaimer:

This is only a summary of the product features. The actual benefits available shall be described in the policy, and will be subject to the policy terms, conditions and exclusions.

For more details on risk factors, terms and conditions read the sales brochure and speak to Your advisor before concluding a sale.

Prohibition of Rebates (under section 41 of Insurance Act, 1938):

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurers. Any person making default in complying with the provision of this section shall be punished with fine, which may extend to five hundred rupees.

Insurance is a subject matter of solicitation

Enclosed:

Annexure - "Illustration of Benefits"