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IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

AROGYA SANJEEVANI POLICY, CHOLA MS

Policy Wordings
CHOHLIP20035V021920

1. **PREAMBLE**
   This policy is a contract of insurance issued by Cholamandalam MS General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Person'). The policy is based on the statements and declaration provided in the proposal form by the proposer and is subject to receipt of the requisite premium.

2. **OPERATIVE CLAUSE**
   If during the policy period one or more Insured Person(s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the Policy Schedule.

   Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

3. **DEFINITIONS**
   The terms defined below and at other juncture in the policy have the meanings ascribed to them wherever they appear in this Policy and, where the context so requires, references to the singular include references to the plural; reference to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means
2. **Age** means age of the Insured Person on last birthday as on date of commencement of the Policy.
3. **Any one Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.
4. **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
5. **AYUSH Hospital** is a healthcare facility where in medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   1. Central or State Government AYUSH Hospital or
   2. Teaching hospital attached to AYUSH College recognised by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy ; or
   3. AYSUH hospital ,standalone or co-located with in-patient healthcare facility of any recognised system of medicine ,registered with local authorities ,wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion :
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to insurance company's authorized representative.

6. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC) ,Primary Health Centre(PHC) ,Dispensary ,Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion :
    i. Having qualified AYUSH Medical Practitioner in charge ;
    ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    iii. Maintaining daily records of the patients and making them accessible to insurance company's authorized representative.
7. **Break in policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
8. **Cashless facility** means a facility extended by the Insurer to the insured person where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.
9. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
10. **Congenital Anomaly** refers to a condition(s) which is present since birth, which is abnormal with reference to form, structure or position.
    a. **Internal Congenital Anomaly:** Congenital anomaly which is not in the visible and accessible parts of the body.
    b. **External Congenital Anomaly:** Congenital anomaly which is in the visible and accessible parts of the body.
11. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.
12. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
13. **Day Care Centre** means any institution established for day care treatment of disease/injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
    a. has qualified nursing staff under its employment;
    b. has qualified medical practitioner(s) in charge;
    c. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel
14. **Day care treatment** means medical treatment and/or surgical procedure which is

a. undertaken under general or local anaesthesia in a hospital / day care centre in less than 24 hours because of technological advancement and
b. which would have otherwise required Hospitalisation of more than 24 hours

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

15. **Dental treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery
16. **Disclosure to information norm:** The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
17. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:
    i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii. the patient takes treatment at home on account of non-availability of room in a hospital.
18. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
19. **Family** means , the Family that consists of the proposer and any one or more of the family members as mentioned below:
    i. Legally wedded spouse
    ii. Parents and Parents-in-law
    iii. Dependent children (i.e natural or legally adopted) between the age of 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
20. **Grace period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
21. **Hospital** means any institution established for inpatient care and day care treatment of disease and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least ten in-patient beds in towns having a population of less than ten lakhs and at least fifteen in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

22. **Hospitalisation** means admission in a Hospital for a minimum period of twenty four (24) consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.
23. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
    a. **Acute condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b. **Chronic condition** means a disease, illness, or injury that has one or more of the following characteristics:
        i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
        ii. it needs ongoing or long-term control or relief of symptoms
        iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        iv. it continues indefinitely
        v. it recurs or is likely to recur.
24. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner
25. **In Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
26. **Insured Person** means person(s) named in the Schedule of the Policy.
27. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
28. **ICU Charges** (Intensive Care Unit) charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
29. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
30. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
31. **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
32. **Medically necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of the illness or injury suffered by the Insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

33. Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

34. **Network Provider** means Hospitals enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

35. **Non- Network Provider** means any hospital that is not part of the network.

36. **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

37. **Out Patient (OPD) treatment** means the one in which the Insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

38. **Pre-existing Disease(PED) means any condition, ailment, injury or disease:**
    a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the Insurer or its reinstatement
    b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

39. **Pre-Hospitalisation Medical Expenses m**eans medical expenses incurred during the period of 30 days preceding the Hospitalisation of the Insured Person, provided that
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    b. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

40. **Post-Hospitalisation Medical Expenses m**eans medical expenses incurred during the period of 60 days immediately after the insured person is discharged from the hospital ,provided that
    a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
    b. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company

41. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms and conditions on which the policy is issued to the Insured person

42. Policy period means the period between the commencement date and earlier of
    a. The Expiry Date specified in the Policy Schedule
    b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with Cancellation clause of the policy.

43. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy

44. **Policy year** means a period of twelve months beginning from the date of commencement of the Policy period and ending on the last day of such twelve month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the Schedule.
45. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
46. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
47. **Reasonable and Customary** Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.
48. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
49. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses
50. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
51. **Sub Limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit
52. **Sum Insured** means pre-defined limit specified in the Policy Schedule .Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person(on Individual basis) or all Insured persons (on Floater basis) during the Policy Year (i.e., per annum for multi-year tenure) within the Policy Period.
53. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner,
54. **Third Party Administrator (TPA)** means a company registered with the Authority and engaged by an insurer for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy

4.1 Hospitalisation

The Company shall indemnify the reasonable and customary medical expenses incurred for Hospitalisation of the Insured Person during the Policy Year ,upto the Sum Insured and Cumulative Bonus specified in the policy schedule ,for,

i. Room Rent, Boarding, Nursing expenses as provided by the Hospital/Nursing Home upto 2% of Sum Insured subject to maximum of Rs 5,000 per day
ii. Intensive Care Unit (ICU)/Intensive Cardiac Care Unit (ICCU) expenses upto 2% of Sum Insured subject to maximum of Rs 10,000 per day.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants ,Specialist Fees whether paid directly to the treating doctor /surgeon or to the hospital
iv. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1 Other Expenses

i. Expenses incurred on treatment of cataract subject to the sublimits
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs 2,000 per hospitalisation

Note:

1. Expenses of Hospitalisation for a minimum period of 24 consecutive hours shall only be admissible .However, the time limit shall not apply in respect of Day Care Treatment.
2. In case of admission to a room /ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement /payment of all other expenses incurred at the Hospital , with exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges

4.2 **AYUSH Treatment**

The Company shall indemnify the reasonable and customary medical expenses incurred for inpatient care and Day Care treatment under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum Insured as specified in the policy schedule in any AYUSH hospital.

4.3 **Cataract Treatment**

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs 40,000, whichever is lower, per each eye in one policy year.

4.4 **Pre Hospitalisation**

The Company shall indemnify pre hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalisation covered under the policy.

4.5 **Post Hospitalisation**

The Company shall indemnify post hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalisation covered under the policy.

4.6 The following procedures will be covered (wherever medically indicated) either as an in -patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specifically in the policy schedule , during policy period: The prevalent treatment / procedures mentioned below are only illustrative and not exhaustive. Any other treatment using advanced technology shall also be considered under Modern Treatment for the purpose of this cover.

A. Uterine Artery Embolization and HIFU(High intensity focussed ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy –Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the prostrate(Green laser treatment or holmium laser treatment)
K. IONM –(Intra Operative Neuro Monitoring)
L. Stem cell therapy : Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

4.7 The expenses that are not covered in this policy are placed under List-I of Annexure –A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure –A respectively

4.8 Domiciliary Hospitalisation

The Company shall indemnify the Reasonable and Customary Medical Expenses incurred by an **Insured Person** for medical treatment taken at his/her home which would otherwise have required Hospitalization provided:

a) on the advice of the attending Medical Practitioner, the **Insured Person** could not be transferred to a Hospital or
b) a Hospital bed was unavailable, and provided that:
   I. The condition for which the medical treatment is required continues for at least 3 days, in which case the Policy pays reasonable cost of necessary medical treatment for the entire period
   II. Pre-hospitalisation and Post hospitalisation expenses will be covered under this benefit in accordance with Section 4.4 and 4.5 respectively.

Cashless facility will not be available for such a claim. Payment under this benefit will reduce the Base Sum Insured.

Specific Exclusion applicable to Domiciliary Hospitalisation:

No payment will be made under this benefit, if the condition for which the Insured Person requires medical treatment towards following ailments:

1. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza
2. Arthritis, Gout and Rheumatism,
3. Chronic Nephritis and Nephritic Syndrome,

4. Diarrhoea and all type of Dysenteries including Gastroenteritis,
5. Diabetes Mellitus and Insupidus,
6. Epilepsy,
7. Hypertension,
8. Pyrexia of unknown Origin.

5. **Renewal Benefit:**

5.a Cumulative Bonus(CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year .If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued .However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on an individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same insured person.
ii. In case where the policy is on a floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured persons
iii. CB shall be available only if the policy is renewed /premium paid within the Grace period
iv. If the Insured persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured person under the expiring policy and such expiring policy has been Renewed on a Floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed policy shall be the one that is applicable to the lowest among all the Insured Persons.
v. In case of floater policies where Insured Persons renew their expiring policy by splitting the Sum Insured into two or more floater policies /individual polices or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed policies in the proportion of the Sum Insured of each Renewed Policy
vi. If the Sum Insured has been reduced at the time of Renewal , the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy
vii. If the Sum Insured has been increased at the time of Renewal , the applicable CB shall be calculated on the Sum Insured of the last completed Policy Year
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

6. **Waiting Period**

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1 Pre –Existing Diseases (Code –Excl01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 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 norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2 First Thirty Day Waiting Period (Code –Excl03)

a) Expenses related to the treatment of any illness within 30 days 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.

6.3 Specific Waiting Period (Code –Excl02)

a) Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first Policy with the Insurer. 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.

i. 24 Months Waiting period

i. Benign ENT disorders
ii. Tonsillectomy
iii. Adenoidectomy
iv. Mastoidectomy
v. Tympanoplasty
vi. Hysterectomy
vii. All internal and external benign tumours,cysts,polyps of any kind, including benign breast lumps
viii. Benign prostate hypertrophy

ix. Cataract and age related eye ailments
x. Gastric/Duodenal Ulcer
xi. Gout and Rheumatism
xii. Hernia of all types
xiii. Hydrocele
xiv. Non-infective Arthritis
xv. Piles, Fissures and Fistula in anus
xvi. Pilonidal sinus, Sinusitis and related disorders
xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
xviii. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy
xix. Varicose Veins and Varicose ulcers
xx. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis and Osteoporosis

7. **Exclusions**

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

7.1 Investigation & Evaluation – (Code – Excl04):

a. Expenses related to any admission primarily for diagnostics and evaluation purposes
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

7.2 Rest Cure, rehabilitation and respite care – (Code – Excl05):

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

7.3 Obesity/Weight Control: Code – (Excl06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a. Greater than or equal to 40 or
   b. 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:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease

iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

7.4 Change-of-Gender treatments: (Code – Excl07): Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

7.5 Cosmetic or plastic Surgery: (Code – Excl08): 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.

7.6 Hazardous or Adventure sports: (Code – Excl09): 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.

7.7 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.

7.8 Excluded Providers: (Code – Excl11): 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 upto the stage of stabilization are payable but not the complete claim.

7.9 Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.**(Code – Excl12**)

7.10 Treatments received in health 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 – Excl13)**

7.11 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 – Excl14)**

7.12 Refractive Error: (Code – Excl15): Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

7.13 Unproven Treatments (Code – Excl16): 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.

7.14 Sterility and Infertility: (Code – Excl17): Expenses related to, Sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

7.15 Maternity Expenses: (Code – Excl18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

7.16 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolution, insurrections, mutiny, military or usurped power,seizure,capture,arrest,restraints and derailments of all kinds.

7.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission , discharge, dispersal, release or escape of any solid , liquid or gaseous chemical compound which , when suitably distributed , is capable of causing any Illness ,incapacitating disablement or death
c) Biological attack or weapons means the emission , discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness ,incapacitating disablement or death.

7.18 Any expenses incurred on OPD treatment

7.19 Treatment taken outside the geographical limits of India.

7.20 In respect of existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to the coverage for specified ICD codes.

8. **Moratorium Period:** After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

9. **CLAIM PROCEDURE**

1.1 **Procedure for Cashless claims**

i. Treatment may be taken in a network provider as well as identified list of hospitals by GIC for common empanelment through anywhere cashless facility and is subject to pre authorisation by the Company or its authorised TPA.
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorisation

iii. The Company /TPA upon getting cashless request form and related medical information from the insured person/network provider will issue pre-authorisation letter to the hospital after verification
iv. At the time of discharge , the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses
v. The Company/TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medial details
vi. In case of denial of cashless access the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.

1.2 **Procedure for Reimbursement of claims**

For reimbursement of claims the insured person may submit the necessary document to TPA (if applicable)/Company within the prescribed time limit as specified hereunder:

SI. No	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalisation ,day care and pre hospitalisation expenses	Within thirty days of discharge from hospital
2.	Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment

9.1 Notification of Claim:

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

Type of hospitalization	Turn Around Time	
Cashless - Admission in Network Hospital	**Planned Hospitalization:** pre-authorization has to be obtained 72 hours prior to the date of planned admission	**Emergency Hospitalization**: within 48 hours of an emergency admission
Reimbursement - Admission in Non - Network Hospital (E mail: customercare@cholams.murugappa,com) or phone (@ Toll free no. 1800-208-9100)	**Planned Hospitalization** - Claim intimation has to be given to us on email or at the Toll free Number within 48 hours for planned hospitalization	**Emergency Hospitalization:** Claim intimation has to be given to us on email or at the Toll free Number within 24 hours of an emergency hospitalization

9.2 Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit:

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical Practitioner's prescription advising admission
iv. Original Bills with itemized break –up
v. Payment receipts

vi. Discharge Summary including complete medical history of the patient along with other details
vii. Investigation /Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed(for surgical cases)
ix. Sticker/Invoice of the Implants ,wherever applicable
x. MLR(Medico Legal Report) copy if carried out and FIR(First Information report) if registered, where ever applicable
xi. NEFT details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC(Identity proof with Address) of the proposer , where claim liability is above Rs 1 Lakh as per AML guidelines
xiii. Legal heir/succession certificate , wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim

Note:

1. The company shall only accept bills/invoices/medical treatment related documents in the Insured person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

9.3 Co-Payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

If Risk based Co-Payment is mentioned in the policy schedule, the standard Co-Payment of 5% shall not be applicable for the Insured and only risk based Co-Payment shall be applied on the claim amount admissible.

9.4 Claim settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim ,as the case may be, within 30 days from the date of receipt of last necessary document
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate of 2% above the bank rate
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

iv. In the case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate of 2% above the bank rate from the date of last necessary document to the date of payment of claim.

9.5 Services Offered by TPA

Not Applicable

9.6 Payment of Claim

All claims under the policy shall be payable in Indian currency only.

10. GENERAL TERMS AND CONDITIONS

10.1 Disclosure of information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

10.2 Condition precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

10.3 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary ,accordingly.

10.4 Records to be maintained

The Insured shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative to inspect such records. The Policyholder or Insured Person shall furnish such information as the company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

10.5 **Complete Discharge**

Any payment to the Insured person or his/her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the policy shall in all cases be full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

10.6 **Notice and Communication**

i. Any notice ,direction ,instruction or any other communication related to the Policy should be made in writing
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule
iii. The Company hall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule

10.7 Territorial limit

All medical treatment for the purpose of this insurance will have to be taken in India only

10.8 Multiple policies

1. In case of multiple policies taken by an Insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require settlement of insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policyholder shall be treated as the Primary Insurer and shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Policyholder having multiple policies shall also have the right to prefer claims under this policies for the amounts disallowed under any other policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle claim subject to the terms and conditions of this policy
3. If the amount claimed exceeds the sum insured under a single policy, the Primary Insured shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions.
4. Where the insured has policies from more than one insurer to cover the same risk on an indemnity basis , the insured shall only be indemnified the hospitalisation costs in accordance with the terms and conditions of the chosen policy

10.9 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means the following acts committed by the Insured person or his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance policy:

a) The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true
b) The active concealment of a fact by the Insured person having knowledge or belief of the fact
c) Any other act fitted to deceive
d) Any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on ground of fraud, if any insured person/beneficiary can prove that the misstatement was true to best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

10.10 Cancellation

i. The policyholder may cancel this policy at any time during the term, by giving 7 days written notice in writing and in such an event, the Company shall

a. refund proportionate premium for the unexpired policy period, if the term of policy upto one year and there is no claim(s) made during the policy period

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

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.

10.11 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In case his /her (Insured person) demise.
   However the cover shall continue for the remaining Insured Persons till the expiry of the Policy Period. The other insured persons may also apply to renew the Policy.
   In case, the other insured person is a minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court.
   All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application
   Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However the policy is subject to renewal on the due date as per the applicable terms and conditions.

10.12 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

10.13 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 atleast 30 days before the policy renewal date. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for

pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

10.14 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. If such person is presently covered and has been continuously covered without any lapses under any Health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

10.15 Renewal of Policy

The health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium clause of the policy.

i. Renewal shall not be denied on the ground that the Insured had made a claim or claims in the preceding years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy period
iii. At end of the Policy Period, the policy shall terminate and can be renewed with the Grace period to maintain the continuity benefits without Break in Policy. Coverage is not available during the grace period
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

10.16 Premium payment in instalments

If the Insured person has opted for Payment of Premium on an instalment basis i.e Yearly, Half Yearly , Quarterly or Monthly, as mentioned in Your Policy Schedule /Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days in case of Monthly and 30 days in case of Single/Yearly/Half-yearly/Quarterly premium payment mode would be given to pay the instalment premium due for the policy
ii. The policy will be in force during such grace period and any claim arising during the grace period will be payable subject to policy terms and conditions.
iii. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of premium within the stipulated grace Period
iv. No interest will be charged if the instalment premium is not paid on due date
v. In case the instalment premium due not received within the Grace Period , the Policy will get cancelled
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable

10.17 Possibility of Revision of Terms of the Policy including the Premium Rates
The company may revise or modify the terms of the policy including the premium rates with prior approval of the Product Management Committee, of the Company. The insured person shall be notified three months before the changes are effected.

10.18 Free Look Period
Every policyholder of new individual health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy and to return the same if not acceptable.

Free Look Period shall not be applicable on renewals or at the time of porting/migrating the policy.

lf the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges, where the risk has not commenced or
ii. 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, expenses if any incurred by the Company on medical examination of the policyholder and stamp duty charges or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period, expenses if any incurred by the Company on medical examination of the policyholder and stamp duty charges

10.19 Endorsements (Changes in Policy)

i. This Policy constitutes the complete contract of insurance. The Policy cannot be modified by anyone (including an insurance agent or broker) except the Company .Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the Company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India

10.20 Change of Sum Insured
Sum Insured can be changed (increased /decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

10.21 Terms and Conditions of the Policy
The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and read together as one document

10.22 Nomination
The policyholder is required at the inception of the policy and at the time of renewal to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder .Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule /Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee , to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

10.23 Assignment
The policy can be assigned subject to applicable laws.

10.24 Withdrawal of Policy:
a. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the policy.
b. Insured person will have the option to migrate to similar health insurance product available with the company at the time of renewal with all the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

10.25 Risk Loading / Co-Payment or Sublimit:
Risk loading (excluding taxes) on premium payable or Co-Payment or Sublimit may be applied based on the details of the Insured Person's health status, habits and lifestyle, past medical records, declarations on the Proposal Form and results of the Pre-Policy Medical check-up (PPMC) or disclosures in the Video-MER and Tele-MER or Welcome Calling.

- The maximum risk loading for an individual shall not exceed 150% per diagnosis / medical condition and an overall risk loading of 200%
- The maximum Co-Payment for an individual shall not exceed 30% per diagnosis / medical condition and an overall co-payment of 50%
- The sublimit for an individual shall not exceed 10% of the Sum Insured or a maximum of Rs. 1 Lakh per diagnosis / medical condition, whichever is less

These loadings or Co-payment or sublimit are applicable from commencement date of the policy including subsequent renewal(s) or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured)

A specific exclusion or Pre-existing condition exclusion may be applied on a medical condition/disease based on the details of the Insured Persons, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and results of the Pre-Policy Medical check-up or disclosures in the Video-MER and Tele-MER or Welcome Calling

These loadings or Co-payment or sublimit or specific exclusions may only be applied if the proposal is accepted with the declared illness/ findings in the Medical Reports submitted / PPMC Reports, at the time of underwriting and only if the proposed policyholder accepts these loadings or Co-payment or sublimit or specific exclusions being applied for the underlying illness/condition at the time of underwriting.

In case of Migration and Portability proposals, the Risk Loading / Sub-limits / Co-Payments / Specific Exclusions shall be applied as stated above.

10.26 Existing Diseases allowed to be covered after the applicable waiting period:
In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule shall be covered immediately after the expiry of the thirty six months waiting period.

REDRESSAL OF GRIEVANCE
Mechanism for Grievance Redressal:-
In case of any grievance the insured person may contact the company through

Website : www.cholainsurance.com
Toll free : 1800 208 9100
E-Mail : customercare@cholams.murugappa.com
Courier : Manager , Customer Care, Chola MS General Insurance Company Limited, Hari Nivas Towers First Floor, #163, Thambu Chetty Street, Parry's Corner, Chennai -600001

Procedure of Grievance Redressal
- Please write to customercare@cholams.murugappa.com to register your complaint.
- In Case of Senior Citizen please write to seniorcitizensupport@cholams.murugappa.com or call our Toll free @ 1800 208 9100 (for Health products)
- On lodging the complaint, a complaint reference number will be provided. An acknowledgement will also be sent with the details of turn around time for resolution and complaint registration details.
- In case you are not happy with the resolution provided or delay of greater than 7 working days, you may follow the below escalation matrix.

Escalation Matrix
- In case you are dissatisfied with the response or have not received a response, you may escalate the same to our Nodal Officer – Nodalescalation@cholams.murugappa.com (Quoting the previous Service request number)
- In case you are still unhappy with the response or have not received a response within 7 working days, you may escalate the same to our Chief Grievance Officer - GRO@cholams.murugappa.com (Quoting the previous Service request number)
- If after having followed the above steps and your issue still remain unresolved, you may approach the Insurance Ombudsman for Redressal. Login to https://www.cioins.co.in/Ombudsman to get details on Insurance Ombudsman Offices.
  Insurance Ombudsman- The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure –B

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai – 600 001.
Toll free: 1800 208 9100, T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

AROGYA SANJEEVANI POLICY, CHOLA MS

Policy Wordings
CHOHLIP20035V021920

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation.

1. TABLE OF BENEFITS

Name	Arogya Sanjeevani Policy, Chola MS
Product Type	Individual/Floater
Category of Cover	Indemnity
Sum Insured	INR On Individual basis – SI shall apply to each individual family member On Floater Basis – SI shall apply to the entire family
Policy Period	1/2/3 Years
Eligibility	Policy can be availed by persons from 18 of age, as Proposer .Proposer with higher age can obtain the policy for family, without covering self. Policy can be availed for Self and the following family members i. Legally wedded spouse ii. Parents and Parents-in-law iii. Dependent Children (i.e natural or legally adopted) between the age of 3 months to 25 Years. If the child above 18 years is financially independent , he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly, Half-yearly, Quarterly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for monthly mode of payment a fixed period of 15 days be allowed as grace period
Hospitalisation Expenses	Expenses of Hospitalisation for a minimum of 24 consecutive hours only shall be admissible Time limit of 24 Hours shall not apply when the treatment undergone in a Day Care Centre
Pre Hospitalisation	For 30 days prior to the date of hospitalisation
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/doctors fee	1. Room Rent ,Boarding, Nursing Expenses all inclusive as provided by the Hospital/Nursing Home upto 2% of the Sum Insured subject to maximum of Rs 5,000 per day 2. Intensive Care Unit (ICU) charges /Intensive Cardiac Care Unit(ICCU) charges all inclusive as provided by the Hospital /Nursing Home up to 5% of the Sum Insured subject to maximum of Rs 10,000 per day
Cataract Treatment	Up to 25 % of Sum Insured or Rs 40,000 ,whichever is lower , per eye, under one policy year
AYUSH	Expenses incurred for Inpatient Care Treatment under Ayurveda, Yoga and Naturopathy ,Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the Policy Schedule
Domiciliary Hospitalisation	The Company shall indemnify the Reasonable and Customary Medical Expenses incurred by an **Insured Person** for medical treatment taken at his/her home

	which would otherwise have required Hospitalization subject to the terms and conditions specified under the cover
Pre-Existing Disease	Only PED's declared in the Proposal form and accepted for coverage by the company shall be covered after a waiting period of 3 Years
Renewal Benefit	**Cumulative Bonus:** Increase in Sum Insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim, the cumulative bonus shall be reduced at the same rate.
Co Pay	5% Co pay on all claims. If Risk based Co-Payment is mentioned in the policy schedule, the standard Co-Payment of 5% shall not be applicable for the Insured and only risk based Co-Payment shall be applied on the claim amount admissible.

AN N E X U R E -A *(attached to and forming part of policy wordings)*

LIST I – Items for which coverage is not available in the policy	
Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICES CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISON CHARGES
23	SURCHARGES

24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINLT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/SHORT/HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELTT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES – SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDER LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERYKIT, ORTHOKIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT

64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU0DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSE
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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LIST III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1	HAIR REMOVAL CREAM
2	DISPOSABLE RAZORS CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD, CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP – COST
8	HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES – DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOLT SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

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Annexure B

The contact details of the **Insurance Ombudsman** offices are as below:

Sl.No	Office of Insurance Ombudsman	Address	E-mail	Landline Nos.
1	AHMEDABAD	Jeevan Prakash, 6th Floor, Near S.V.College, Relief Road, Tilak Marg, Ahmedabad - 380 001. Gujarat	Email: bimalokpal.ahmedabad@cioins.co.in	Tel.: 079 – 25501201 / 079 - 25501202
2	BENGALURU	Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078.	Email: bimalokpal.bengaluru@cioins.co.in	Tel.: 080 – 26652048 / 080 - 26652049
3	BHOPAL	LIC of India Zonal Office Bldg, 1st Floor, South Wing, Jeevan Shiksha, Opp.Gayatri Mandir, 60-B, Hoshangabad Road, Bhopal - 462011	Email: bimalokpal.bhopal@cioins.co.in	Tel.: 0755 - 2769201 / 0755 – 2769202 / 0755 - 2769203
4	BHUBANESHWAR	62, Forest park, Bhubaneshwar - 751 009.	Email: bimalokpal.bhubaneswar@cioins.co.in	Tel.: 0674 – 2596455 / 0674 – 2596429 / 0674 – 2596003 / 0674 - 2596461
5	CHANDIGARH	Jeevan Deep, Ground Floor, LIC of India Bldg, SCO 20-27, Sector 17-A, Chandigarh - 160017	Email: bimalokpal.chandigarh@cioins.co.in	Tel.: 0172 – 2706468 / 0172 - 2707468
6	CHENNAI	Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI -600 018.	Email: bimalokpal.chennai@cioins.co.in	Tel.: 044 - 24333668 / 044 - 24333678
7	DELHI	2/2 A, 1st Foor, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002.	Email: bimalokpal.delhi@cioins.co.in	Tel.: 011 – 23232481 / 011 – 23213504 / 011 – 46013992 /
8	GUWAHATI	Jeevan Nivesh Bldg, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati - 781001	Email: bimalokpal.guwahati@cioins.co.in	Tel.: 0361 - 2632204 / 0361 – 2602205 / 0361 - 2631307
9	HYDERABAD	6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Email: bimalokpal.hyderabad@cioins.co.in	Tel.: 040 – 23312122 / 040 – 23376599 / 040 – 23376991 / 040 – 23328709 / 040 - 23325325
10	JAIPUR	Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Ambedkar Circle, Jaipur - 302 005.	Email: bimalokpal.jaipur@cioins.co.in	Tel.: 0141 - 2740363

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Sl.No	Office of Insurance Ombudsman	Address	E-mail	Landline Nos.
11	KOCHI	10th Floor, LIC Bldg, Jeevan Prakash, Opp Maharaj College Ground, M.G.Road, Ernakulam, Kochi - 682011	Email: bimalokpal.ernakulam@cioins.co.in	Tel.: 0484 - 2358759
12	KOLKATA	Hindustan Bldg. Annexe, 4th Floor,	Email: bimalokpal.kolkata@cioins.co.in	Tel.: 033 - 22124339 / 033 - 22124341
13	LUCKNOW	Jeevan Bhawan, Phase-II, 6th Floor, Nawal Kishore Road, Hazratganj, Lucknow - 226001	Email: bimalokpal.lucknow@cioins.co.in	Tel.: 0522 – 4002082 / 0522 - 3500613
14	MUMBAI	3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Email: bimalokpal.mumbai@cioins.co.in	Tel.: 69038800 / 69038833
15	NOIDA	Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Noida-201301, Distt: Gautam Buddh Nagar, Uttar Pradesh	Email: bimalokpal.noida@cioins.co.in	Tel.: 0120-2514252 / 0120-2514253
16	PATNA	2nd Flood, North Wind, Lalit Bhawan, Bailey Road, Patna - 800 001	Email: bimalokpal.patna@cioins.co.in	Tel.: 0612-2547068
17	PUNE	Jeevan Darshan Bldg., 3rd Floor, LIC of India Bldg, N.C. Kelkar Road, Narayan Peth, Pune- 411 030.	Email: bimalokpal.pune@cioins.co.in	Tel: 020-24471175

Section 11: Flexi OP Care- Add On Cover
UIN:CHOHLIA23045V012223
(on payment of additional premium)

1. GENERAL CONDITIONS

1. It is hereby agreed and understood that this Add on Cover can be bought only along with the Base Policy and cannot be bought in isolation or as a separate product.
2. The Add on Cover is subject to the terms and conditions stated below and the Policy terms, conditions and applicable endorsements of the Base Policy.
3. The Add on Cover shall be available under your policy only if the same is specifically opted on payment of applicable premium and specified in the Policy Schedule.
4. The coverage under the Add-on cover will be on Individual basis
5. The Add-on cover cannot be opted during mid-term of Base Policy

6. Lifelong renewal along with the Base Policy
7. Any discount and loading applicable, if any on Base Policy will not be applicable on this Add-on cover
8. The list of Health Insurance Products for which the Add-on cover benefit option is available, is placed at Annexure 1.

2. DEFINITIONS

The terms defined in the Base Policy and at other junctures in the Add-on Wording have the meaning ascribed to them wherever they appear in this Add-on cover and, where appropriate, references to the singular include references to the plural; references to the male include the female and third gender and references to any statutory enactment include subsequent changes to the same. The cover is subject to the terms defined below and terms defined in the Base Policy.

1. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

2. **Base Policy** means any retail health Insurance policy issued by 'Cholamandalam MS General Insurance Company Limited' including its terms and conditions, any annexure thereto and the Policy Schedule (as amended from time to time), the information statements in the proposal form and the Policy wording (including endorsements, if any) and to which this Add-on is attached.

3. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of Out Patient (OP) services availed by the insured in accordance with the add-on terms and conditions, are directly made to the network facility by the insurer upto the limits mentioned in the policy.

4. **Diagnostic Test** means investigations such as X-ray or blood tests to find the cause of your symptoms and medical condition.

5. **General Practitioner -** General practitioners (GPs) is a Doctor/Medical Practitioner/Physician who did not specialize in any field of medicine after successful completion of graduation from medical school and treat all common medical conditions, refer patients to hospitals and other medical services for urgent and Specialist treatment. Provided such General Practitioner qualifies the National Exit Test held under section 15 of National Medical Commission Act, 2019 and is granted a license to practice medicine and shall have his/her name and qualifications enrolled in the National Register or a State Register, as the case may be maintained under National Medical Commission Act, 2019. Provided that a person who has been registered in the Indian Medical Register maintained under the Indian Medical Council Act, 1956 (102 of 1956) (i) prior to 02nd September 2019, and (ii) before the National Exit Test becomes operational under sub-section (3) of section 15 of National Medical Commission Act, 2019, shall be deemed to have been registered under National Medical Commission Act, 2019 and be enrolled in the National Register maintained under National Medical Commission Act, 2019.

6. **Network Facility** means hospitals, clinics, diagnostic centers, Pharmacies that the Company or the Service Provider or jointly by the Insurer and Service Provider to provide medical services to an insured by a cashless facility.

7. **Policy Period** shall mean the period for which the insured is covered under the Add-on as mentioned in the Policy Schedule and which shall be in consonance of the policy period under the Base Policy.

8. **Service Provider** shall mean and include all or any legal entity, who is engaged by the Insurer to provide access to the services that are designed to assist the Insured to avail the listed OP Services under the add-on by providing their digital platform and/or Network Facility.

9. **Tele-consultation** means The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.

10. **Waiting period** refers to the period during which we shall not be liable to make any payment for any claim for treatment. This is not applicable if caused directly due to an accident during the policy period.

3. PERSONS ELIGIBLE FOR COVER:

Insured persons who have opted for the Company's Base Policy as defined, can buy this Add-on for insured himself/herself and or his/her family members as listed below and covered under the Base Policy.

i. Legally wedded spouse
ii. Children upto 4 (i.e. natural or legally adopted) and
iii. Parents/ Parents in law

Tenure: This Add-on cover shall be issued for a term of 1 or 2 or 3 years as per the tenure of the Base Policy. ie. If Base Policy is for one year, then the Add-on shall be for 1 year and if Base policy is for two years, then the Add-on shall be for 2 years etc.

4. SCHEDULE OF BENEFITS:

During every Policy Year under the Add-on, Insured Person will be eligible for coverage as per the plan selected from the below table. Plan opted at policy level shall be applicable separately for each Insured Person covered under this Add on, even if the Base Policy is Individual Sum Insured plan or floater plan. This cover will be applicable each year for Add-on cover period, more than one year.

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai – 600 001.
Toll free: 1800 208 9100, T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

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Benefits applicable for Individual Insured will be based on the Plan opted under the Add-on cover.

Coverage / Plan			Flexi OP Care 1	Flexi OP Care 2	Flexi OP Care 3	Flexi OP Care 4
BASE COVERS	**Out-Patient (OPD) Consultation**	**Tele-consultation**	Not Available	Not Available	Unlimited no. of Tele-consultations with General Practitioner from Network Facility	Unlimited no. of Tele-consultations with General Practitioner from Network Facility including Dental consultations
		In-person consultation	Unlimited no. of in-person consultations from Network Facility upto a maximum of Rs. 600/- per consultation on cashless basis	Unlimited no. of in-person consultations from Network Facility upto a maximum of Rs. 600/- per consultation on cashless basis including Dental	Unlimited no. of in-person consultations from Network Facility upto a maximum of Rs. 600/- per consultation on cashless basis	Unlimited no. of in-person consultations from Network Facility upto a maximum of Rs. 600/- per consultation on cashless basis including Dental
	Prescription Diagnostics		Upto a Maximum of Rs.600/- followed by each consultation from Network Facility on cashless basis	Upto a Maximum of Rs.600/- followed by each consultation from Network Facility on cashless basis	Upto a Maximum of Rs.600/- followed by each consultation from Network Facility on cashless basis	Upto a Maximum of Rs.600/- followed by each consultation from Network Facility on cashless basis
VALUE ADDED SERVICES	**Discounted Pharmacy**		Not Available	Not Available	Discount as applicable on every purchase of pharmacy from the Network Facility on the Digital platform	Discount as applicable on every purchase of pharmacy from the Network Facility on the Digital platform
	Discounted Health Checkups		Not Available	Not Available	Discount on Health Check up's as applicable	Discount on Health Check up's as applicable from the Network

				from the Network Facility on the Digital platform	Facility on the Digital platform
	Dental Benefits	Not Available	1. Dental cleaning from the Network facility 2. One IOPA X-ray (if prescribed) from the Network Facility 3. Discount as applicable on all treatment procedures from the Network facility on the Digital platform	Not Available	1. Dental cleaning from the Network facility 2. One IOPA X-ray (if prescribed) from the Network Facility 3. Discount as applicable on all treatment procedures from the Network facility on the Digital platform
	Vision Benefits	Not Available	Lenskart Gold Membership	Not Available	Lenskart Gold Membership
WELLNESS SERVICES	**Daily Health Management & Fitness programs**	Step Tracking, Calorie Counter, Sleep Tracking, Personalized Fitness programs; Mental Health Podcasts across an array of topics such as Yoga, Meditation, Mindfulness, Dance Fitness, Specialist Medical Sessions etc.			

Note:

1. Tele-consultations also include Covid Risk assessment.
2. The Benefits and services availed under this availed Add on Cover is purely based on the Insured Person's own discretion and at own risk. The services provided under the various covers are via third party health service providers/ network providers/ and the Insurer is not responsible for liability arising out of the services provided by these third parties.

5. COVERAGE

Out-Patient services (OPD) listed under Base Cover of this Add-on, can be availed only on cashless basis on the digital platform subject to waiting periods, exclusions, terms and conditions of the Add-on cover.

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The listed covers, Value Added Services and Wellness Services shall be provided through our Service Provider subject to availability at the time of appointment.

A. BASE COVERS:

1. **OPD Consultation:** If at any time during the policy period, the Insured Person suffers from any illness/injury, he or she can avail Out-Patient Tele-consultation or In-Person Consultation upto the limit as mentioned under this Add-on, from a General Medical Practitioner in the network, listed on the Digital Platform of the respective service provider's application.

   The scope of cover under this benefit shall be restricted to charges incurred towards Doctor Consultation. No other charges shall be covered.

2. **Prescribed Diagnostics:** If at any time during the policy period, the Insured Person suffers from any illness / injury, he or she can avail Outpatient diagnostic tests on cashless basis upto the limit as mentioned under this Add-on, from the Network facility on the Digital platform of the respective service provider's application.

   Specific Conditions applicable to Prescribed Diagnostics:
   Insured Person has to upload the Prescription of the Medical Practitioner for the respective diagnostic tests to avail this service.

   The cost of only those diagnostic test prescribed by doctors from the Network Facility on the Digital Platform shall be admissible following Tele-consultation/In-Person Consultation availed through the app. No other charges shall be admissible under the cover.

   Specific Exclusions applicable to Prescribed Diagnostics:
   Genetic studies shall be excluded from the scope of this cover.

B. VALUE ADDED SERVICES:

The Insured shall be eligible to avail the Value Added Services as listed below on the Digital platform, during the policy period:

3. **Discounted Pharmacy:** Purchase of Medicines at his/her own expense from the Network facility on the Digital platform and avail discount as applicable on every purchase.
   Prescription from the Medical Practitioner is mandatory for every Pharmacy Purchase under the cover**.**

4. **Discounted health check-ups:** Avail Health check-ups from the Network Facility on the Digital platform at his/her own expense with a discount as applicable at the time of the Health Checkup.

5. **Dental Benefits:** Following services relating to dental can be availed on cashless basis from the network facility on the Digital platform, during the policy period:

   •Dental cleaning (prophylactic teeth cleaning) once in a policy year from the Network facility

•IOPA X-ray (Intraoral Periapical X ray) - which shows the entire root and a dentist can look for infections, widened pdl space, bone loss (horizontal/ vertical) or bony defect can be availed (if prescribed) once in a policy year from the Network Facility as prescribed by the dentist
•Discounts can be availed on all treatment procedures as prescribed by the dentist from the Network facility on the Digital platform

C. WELLNESS SERVICES:

The Insured Person shall be eligible to avail the following wellness services on the Digital platform of the respective service provider's application, during the policy period:

6. **Daily Health Management:**
   - Step Tracking
   - Calorie Counter
   - Sleep Tracking

7. **Fitness Program:** Personalized Fitness programs & Mental Health Podcasts across an array of topics such as Yoga, Meditation, Mindfulness, Dance Fitness, Specialist Medical Sessions etc.

Specific Conditions applicable to the Add-on Cover:

1. All the consultations, diagnostic tests & pharmacy expenses are covered only if they are scheduled via the Digital Platform.
2. Any consultation done outside of the portal, will not be covered
3. Any amount over and above the limits as mentioned in the Schedule of Benefits has to be borne by the Insured.
4. Only those persons named as insured Persons in the Add-on cover shall be covered.
5. Utilizing this facility alone will not amount to making a claim under any health insurance policy
6. No OP Services under the Add-on can be availed during the break in insurance

6. WAITING PERIOD & GENERAL EXCLUSIONS

A. WAITING PERIOD:

15-day waiting period- Code- Excl03:

a) Expenses related to the treatment of any illness within 15 days 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.

B. GENERAL EXCLUSIONS:

The add-on does not cover any expenses incurred directly, caused by, arising from or in any way attributable to any of the following:

1. **Rest Cure, rehabilitation and respite care – code – Excl05:**

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

2. Tele-consultation, In person consultation and Prescription Diagnostics taken outside the Digital platform is not covered under the Add-on cover
3. If the Tele-consultation, In Person Consultation and Prescription Diagnostics is not availed in the policy year during the Policy Period, the benefit cannot be carried forward to the subsequent policy year during the policy period.
4. Disease arising out of involvement in illegal activities or substance abuse.
5. Treatment other than Allopathy.
6. Inpatient treatments & day-care procedures are not covered under the policy.
7. No medical equipment and associated consumables will be covered under the policy (Example – BP Machine, Thermometer, Syringes, Nebulizer, Hot Water Bags, etc.)
8. Vitamins and tonics used for the treatment of injury or disease will not be covered
9. Food, Food Supplements or Dietary Pills (Example – Horlicks, Glucose, Whey Protein, etc.).
10. Non-Medical Expenses - Registration Fee, Admission Fee, Telephone Charges, Cafeteria Charges, etc.
11. Consultation with Nutritionists - Available only online through the digital platform
12. Physiotherapy and any other therapies are not covered

7. GENERAL CONDITIONS

The Add on Cover is subject to the terms and conditions stated below and the Policy terms, conditions and applicable endorsements of the Base Policy.

1. Notification:

a. Any and all notices and declarations for the attention of the Insurer shall be in writing and shall be delivered to the Insurer's address as specified in the Policy Schedule.
b. Any and all notices and declarations for the attention of any or all of the insured Persons shall be in writing and shall be sent to the Policyholder's address as specified in the Policy Schedule.

2. Claims procedure:

a. Cashless facility is available only at Network facility on the Digital platform. The Service Provider reserves the right to modify, add or restrict any Network Provider Cashless facility at their sole discretion.

b. Claims under the Add-on will be adjudicated only on cashless basis via the Digital platform and are subject to the terms, conditions, waiting periods and exclusions of the Add-on cover.

c. Wherever the services availed exceed the eligibility as applicable under the Add-on for the respective Insured, the difference shall have to be paid directly to the Network Provider by the Insured person/claimant.

d. The diagnostics and Pharmacy services shall only be covered for prescriptions by a Network Medical Practitioner through the Digital Platform.

Steps to avail the cashless cover:

Step 1: Insured person shall receive an activation SMS or WhatsApp message with the link to download the Digital Platform

Step 2: Start downloading the Digital platform of the Service Provider as per the link shared or as mentioned in the Policy Schedule

Step 3: Insured person has to sign up from his/her registered mobile number and verify with One Time Password (OTP).

Step 4: The app will display the details of benefits available for the insured and his/her family and then they can choose the service such as Teleconsultation, Physical Consultation, Diagnostics, Pharmacy purchase as required. Insured Person shall have to raise a request through Digital platform and the appointment details shall be available on the platform.

3. **Territorial Limits:**
The Add-on cover is applicable within the territorial boundaries of India.

4. Transfer:
Benefits under this Add-on cover is not transferrable to anyone else.

5. **Validity of the Cover:**

The Add-on cover for the Insured will terminate at the earliest of the following occurrence

- The expiry date mentioned in the **Policy schedule**
- In case of death of the Insured
- The date of cancellation of this Add-on cover by either Policy holder or Insurer in accordance with the terms and conditions of the Base policy.

6. Disclaimer:
The Service under this add-on is provided by Visit Health Private Limited (Visit Health), an independent Company not affiliated to us. Cholamandalam MS General Insurance Company has entered into an agreement with Visit Health Private Limited, to provide OP services through the Network Facility with Visit Health. Visit Health provides the digital platform and connect the Network Facilities such as hospitals, day, diagnostic centers, Pharmacies and provide necessary services to the Insured Persons who have availed this add-on on payment of applicable premium.

In the event of any change in the Service Provider or inclusion of a new Service Provider in future, the same shall be disclosed in the policy to the Policyholders.

Section 12 – Home Care Treatment –Add on Cover
(on payment of additional premium)
UIN:CHOHLIA22201V012122

1. GENERAL CONDITIONS

1. It is agreed and understood that this Add On Cover can only be bought along with the Underlying Plan and cannot be bought in isolation or as a separate product.
2. The Add On Cover is subject to the terms and conditions stated below and the Policy terms, exclusions, conditions and applicable endorsements of the Underlying Plan.
3. The Add On Cover shall be available under your policy only if the same is specifically opted on payment of applicable premium and specified in the Policy Schedule.
4. All applicable Terms, Exclusions and Conditions of the Underlying Policy shall apply to the Add on Cover.

2. SUM INSURED

a. Daily limit options – Rs.1000/- to Rs. 10,000/- per day in multiples of Rs.500/-
b. Number of days – 5 / 7 / 10 / 15 / 20 / 25 / 30 / 45 / 60 days per annum
c. This add-on cover can be availed on Individual or Family floater basis
d. On Individual basis, it is our maximum liability for each Insured Person for any and all benefits claimed for during the Annual Period (i.e. per annum for multi-year tenure) within the policy period, unless otherwise specified and
e. In relation to a Family Floater, it is our maximum liability for any and all claims made by all the Insured persons during the Annual Period (i.e. per annum for multi-year tenure) within the Policy period, unless otherwise specified.
f. Sum Insured Restoration, if any available under Base Policy shall not be applicable for Home care Treatment under this Add-on cover.

3. DEFINITIONS

The terms defined below and at other junctures in the Add-on cover Wording have the meanings ascribed to them wherever they appear in the Add-on cover and where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

a. Homecare Treatment means treatment availed by the Insured Person at home which in normal course would require care and treatment at a hospital but is actually taken at home provided that:
   a) The Medical Practitioner advices the Insured Person in writing to undergo treatment at home.
   b) There is continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment

c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

b. Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.

4. COVERAGE

a. Homecare Treatment:

This Add-on cover will reimburse the Reasonable and Customary charges medical expenses upto the daily limit as opted and mentioned in the Policy Schedule/Certificate towards Homecare Treatment for the following medical conditions during the policy period upto the maximum number of days opted and mentioned in the policy schedule/certificate per annum, subject to the specific conditions mentioned below.

1. Gastroenteritis
2. Chemotherapy
3. Pancreatitis
4. Dengue
5. Chronic obstructive pulmonary disease management
6. Hepatitis
7. COVID-19

b. Specific Conditions:

a. The treatment in normal course would require care and In-patient treatment at a hospital but is actually taken at home, provided that:
   i. The Medical Practitioner advices the Insured person in writing to undergo treatment at home
   ii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
   iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
   iv. This add on cover shall reimburse the following medical expenses incurred during Home care treatment subject to the terms, conditions, waiting periods and exclusions applicable under the Base policy, to which the Add-on cover is linked with.
      a. Diagnostic tests undergone at home or at diagnostics centre as prescribed by the Medical practitioner
      b. Medicines prescribed in writing
      c. Consultation charges of the medical practitioner
      d. Nursing charges related to medical staff
      e. Medical procedures limited to parenteral administration of medicines
      f. Consumables as listed in Annexure 1 of this cover
b. Pre-hospitalisation and Post hospitalisation expenses shall not be payable under this cover.
c. Claim under this cover shall be on Reimbursement basis.

5. GENERAL CONDITIONS

Claim Procedure:
If You happen to suffer Accidental Bodily Injury or is diagnosed with an Illness which gives rise to or may give rise to a claim, then it is a condition precedent to our liability that You shall immediately :
a. Give us notice of the claim irrespective of notice provided to any other insurer for the same illness in case you are holding multiple insurance policies.
b. Expeditiously give or arrange for us to be provided with any and all information and documentation in respect of the claim and/or our liability for it that may be requested by the Us
c. Claim intimation has to be given to us in writing or mail (E mail: customercare@cholams.murugappa,com) or phone (@ Toll free no. 1800-208-9100) within seven days from the date of hospitalization/injury/death.

Claim documentation submission:
Claim documents as applicable for the In-patient hospitalization cover under the Base policy to be submitted within 30 days of completion of the treatment.

Territorial Limits
The Insurer's liability to make any payment towards illness or accidental injury shall be to make payment within India and in Indian Rupees only for medical services or procedures rendered in or undertaken within India.

Annexure-1 (forming part of the Add-on cover wording)

Sl. No.	List of Consumables covered under the policy
1	BELTS/ BRACES
2	COLD PACK/HOT PACK
3	CARRY BAGS
4	LEGGINGS
5	SANITARY PAD
6	CREPE BANDAGE
7	DIAPER OF ANY TYPE
8	EYELET COLLAR
9	SLINGS
10	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
11	SURCHARGES
12	MEDICAL CERTIFICATE
13	MEDICAL RECORDS
14	WALKING AIDS CHARGES

15	SPIROMETRE
16	STEAM INHALER
17	THERMOMETER
18	CERVICAL COLLAR
19	SPLINT
20	DIABETIC FOOT WEAR
21	LUMBO SACRAL BELT
22	NIMBUS BED OR WATER OR AIR BED CHARGES
23	ABDOMINAL BINDER
24	SUGAR FREE TABLETS
25	ECG ELECTRODES
26	KIDNEY TRAY
27	OUNCE GLASS
28	PELVIC TRACTION BELT
29	PAN CAN
30	TROLLY COVER
31	UROMETER, URINE JUG
32	PULSEOXYMETER CHARGES
33	Glucometer& Strips
34	URINE BAG