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Chola MS
GENERAL INSURANCE

SPECIALISED HEALTH INSURANCE PLAN

FOR PERSONS WITH DISABILITY, MENTAL ILLNESS AND PERSONS WITH HIV/AIDS

INTRODUCING

DIVYANG BIMA, CHOLA MS

'Divyang Bima is a specialised health indemnity insurance that extends to provide financial protection from unforeseen medical emergencies for Persons with Disability, Mental Illness and Persons with HIV/AIDS.

ENTRY AGE

- Adult : 18 years to 65 years of age.
- Dependent Children – New born to 17 years of age
  (Maximum Renewal age for children is 17 years. On renewal after completion of 17 years, such Insured Person will have the option to migrate to new health insurance policy under the same product, with continuity benefits.)

PERSONS WHO CAN BE COVERED

- Persons with Disability of 40% or more disability as certified by the Medical Board appointed by the government for certifying Disability as per the Disability act 2016.
- Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.

SUM INSURED OPTIONS

- Rs. 4 Lakhs
- Rs. 5 Lakhs

TYPE OF SUM INSURED OPTIONS

- Individual Sum Insured – Each covered person will have an independent Sum Insured.
- No multi individual or Floater policies shall be allowed.

POLICY TENURE

One Year

PREMIUM PAYMENT OPTIONS

- Annual or
- Half-Yearly or
- Quarterly or
- Monthly Mode

This option shall be made at the time of proposing for insurance and the opted mode will be shown on the policy schedule. Premium payment option can be changed only at the time of renewal.

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 the policy.

Benefits	
In-Patient Hospitalisation Expenses	Covered
Pre-Hospitalisation	Upto 30 days
Post Hospitalisation	Upto 60 days
Emergency Ground Ambulance	Expenses covered up to Rs. 2000 per hospitalisation
AYUSH	Covered upto 100% of the Sum Insured

Sublimit & Co-Payment	
Room/ Medical Practitioner's fee	Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to maximum of 1% of the sum insured per day Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital/ Nursing Home up to maximum of 2% of the sum insured per day
Cataract Treatment	Up to Rs.40,000/-, per eye in one policy year
Modern Treatment	Covered for listed procedures up to 50% of Sum Insured available for Inpatient Hospitalisation
Co-pay	20% on all claims made under the policy, unless waiver for Co-pay is opted and premium is paid for the same

Waiting Periods	
30 days Waiting period	Applicable
PED waiting period	36 months (For pre-existing diseases other than the pre-existing Disability and HIV/AIDS covered)
Specific Disease/ illness waiting period	24 months
Waiting Period for HIV AIDS Cover	Initial waiting period of 30 days will be applicable for Indemnity basis cover
Waiting Period for Disability Cover	24 months initial waiting period is applicable for the pre-existing Disability covered under the policy.

Specific Conditions applicable for Persons with Disability:

Any reconstructive / Cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy.

Specific Conditions applicable for persons with HIV/AIDS:

This cover will exclude cost for any Anti-Retroviral Treatment.

WAITING PERIOD

1. **Pre –Existing Diseases (Code – Excl 01)**
   - Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months for Pre-existing Disability/ 36 months for all pre-existing conditions other than HIV/AIDS and Disability (as mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.
   - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   - 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.
   - Coverage under the policy after the expiry of 24 months/36 months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. First 30 Days Waiting Period (Code – Excl03)

- 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.
- This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
- The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3. Specific disease/ procedure Waiting Period (Code – Excl02)

- Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months (as mentioned in policy schedule) 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.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- 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.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- 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.

24 Months Waiting Period

- Benign ENT disorders
- Tonsillectomy
- Andenoidectomy
- Mastoidectomy
- Tympanoplasty
- Hysterectomy
- All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
- Benign prostate hypertrophy
- Cataract and age related eye ailments
- Gastric/Duodenal Ulcer
- Gout and Rheumatism
- Hernia of all types
- Hydrocele
- Non-infective Arthritis
- Piles, Fissures and Fistula in anus
- Pilonidal sinus, Sinusitis and related disorders
- Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
- Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy
- Varicose Veins and Varicose ulcers
- Internal Congenital Anomalies (except for New Born)

EXCLUSIONS

1. **Investigation & Evaluation – (Code – Excl04)**
   - Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   - Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. **Rest Cure, Rehabilitation and Respite Care – (Code – Excl05)**
   - 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

3. **Obesity/Weight Control: Code – (Excl06)**

   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   - Surgery to be conducted is upon the advice of the Doctor
   - The surgery/Procedure conducted should be supported by clinical protocols
   - The member has to be 18 years of age or older and
   - 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

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

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.

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. **Breach of law: (Code – Excl10)**

   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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 up to the stage of stabilization are payable but not the complete claim.

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

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)**

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)**

12. Refractive Error: (Code – Excl15)

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

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.

14. Sterility and Infertility: (Code – Excl17)

Expenses related to, Sterility and infertility. This includes:

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

15. Maternity: (Code – Excl18)

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

16. Any medical treatment taken outside India.

17. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

18. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:

a. any nuclear fuel or from any nuclear waste; or

b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission)

c. nuclear weapons material.

d. nuclear equipment or any part of that equipment.

19. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

20. Injury or Disease caused by or contributed to by nuclear weapons/materials.

21. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.

22. Treatment with alternative medicines or Treatment, experimental or any other treatment such as

acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.

23. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

24. Vaccination or inoculation except as post bite treatment for animal bite.

25. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.

26. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.

27. Venereal/ Sexually Transmitted disease

28. Stem cell storage.

29. Any kind of service charge, surcharge levied by the hospital.

30. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

31. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II: of the policy

32. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

33. Treatment other than Allopathy and Ayush.

RENEWAL OF POLICY

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

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

PREMIUM PAYMENT IN INSTALMENTS

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

- Grace period of 15 days for Monthly and 30 days for Quarterly, Half-yearly mode would be given to pay the instalment premium due for the policy.
- 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.
- The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- No interest will be charged if the instalment premium is not paid on due date.
- In case of instalment premium due not received within the grace period, the policy will get cancelled.

- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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.

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

- 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
- 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
- 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.

CLAIMS PROCEDURES

1 Procedure for Cashless claims

- Treatment may be taken in a network provider and is subject to pre authorisation by the Company or its authorised TPA.
- Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorisation
- 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
- At the time of discharge , the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses
- The Company/TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medial details
- 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.

2 Procedure for Reimbursement of claims

For reimbursement of claims the insured person may submit the necessary document to Company within the prescribed time limit as specified hereunder:

Sl. 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

3 Notification of Claim

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

- Within 24 hours from the date of emergency hospitalisation required or before the Insured Person's discharge from Hospital, whichever is earlier
- At least 48 hours prior to admission in Hospital in case of a planned hospitalisation.

4 Documents to be submitted

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

- Duly Completed claim form
- Photo Identity proof of the patient
- Medical Practitioner's prescription advising admission
- Original Bills with itemized break –up
- Payment receipts
- Discharge Summary including complete medical history of the patient along with other details
- Investigation /Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
- Sticker/Invoice of the Implants, wherever applicable
- MLR (Medico Legal Report) copy if carried out and FIR (First Information report) if registered, where ever applicable
- NEFT details (to enable direct credit of claim amount in bank account) and cancelled cheque
- KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML guidelines
- Legal heir/succession certificate, wherever applicable
- Any other relevant document required by Company/TPA for assessment of the claim

NOTE

- The company shall only accept bills/invoices/medical treatment related documents in the Insured person's name for whom the claim is submitted
- 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
- 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

CANCELLATION OF COVER

- 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.
- 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.

MIGRATION

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

- The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- Migration benefit will be offered to the extent of sum of previous insured and accrued bonus (as part of the sum insured), migration benefit shall not apply to any other additional increased Sum Insured.
- Migration under this product shall be allowed only due to withdrawal of the product subject to IRDAI Regulations

PORTABILITY

The Insured Person will have the option to port the Policy to same product of other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under this health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

- The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

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.

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.

APPLICABILITY OF TAX EXEMPTION

- The premium paid for covering Self, Spouse, Dependent Children and Dependent Parents is eligible for deduction under Section 80D of Income Tax Act.
- AML norms as per IRDA guidelines currently in force shall be insisted upon

RISK LOADING

Following are the parameters based on which loadings will be applied.

- Loading based on Body Mass Index

  i Risk loading may be applied on premium payable (excluding taxes and cess) 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. The maximum risk loading for an individual shall not exceed 200%. These loadings are applicable from commencement date of policy including subsequent renewal(s).

ii. These loadings may only be applied if the proposal is accepted with the declared illness/ with the deviated value of medical test report, at the time of underwriting and only if the proposed policyholder accepts these loadings being applied for the underlying illness/condition at the time of underwriting.

iii. The proposal shall be declined wherever more than 2 Co-morbid conditions are disclosed in the proposal form and / or detected during the PPMC or Tele /Video MER.

- Loading for Co-morbidities based on disclosure in proposal form or findings from PPMC, Tele/Video MER for persons existing HIV/AIDS
- Loading for HIV / AIDS condition basis Current CD4 Count less than 501

LOADING FOR PREMIUM PAYMENT OPTION

Payment Option	Loading %
Annual	0%
Half-Yearly	2%
Quarterly	3%
Monthly	4%

GRIEVANCE

In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

For details of grievance officer, kindly refer the link: www.cholainsurance.com

IRDAI Integrated Grievance Management System https://igms.irda.gov.in/

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 I in the policy wording.

Chola MS
GENERAL INSURANCE

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