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Chola MS
GENERAL INSURANCE

THE PERFECT WAY TO

PROTECT YOUR FAMILY'S HEALTH.

INTRODUCING

CHOLA HEALTHLINE

UIN: CHOHLIP24153V052425

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POLICY WORDINGS

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POLICY WORDINGS

We issue this insurance policy to You and/or Your Family based on the information provided by You / Proposer in the proposal form and premium paid by You/ Proposer. This insurance is subject to the following terms and conditions. This policy covers Your Family either on Individual Sum Insured basis or on Floater Sum Insured basis. The method of coverage and the Sum Insured that has been opted by you is mentioned in the Policy Schedule. The term **You/Your/Insured/Insured Person** in this document refers to all the Individual members who will be treated as Insured beneficiary and the term Proposer/Policy Holder in this document refers to Person who has signed the proposal form and in whose name the policy is issued. Also the term **Insurer/Us/Our/Company** in this document refers to **Cholamandalam MS General Insurance Company Limited**.

1. DEFINITIONS

To help **You** understand **Your Policy** the following words and phrases used anywhere within **Your Policy** have specific meanings, which are set out in this section.

1. **Accident means** sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Acquired Immune Deficiency Syndrome (AIDS)** means the meaning assigned to it by the World Health Organization and shall include Human Immune deficiency Virus (HIV), Encephalopathy (dementia) HIV Wasting Syndrome and ARC (AIDS Related Condition).

3. **Age** means completed years on Your last birthday as per the English Calendar regardless of the actual time of birth, at the time of commencement of Policy Period.

4. **Alternative Treatments** are forms of treatments other than treatment “Allopathy” or “modern medicine” and includes Ayurveda, Unani, Sidha, and Homeopathy in the Indian context.

5. **Annual Period** refers to a continuous period of insurance of 12 months within the contract period.

6. **Any One Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

7. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

8. **AYUSH Hospital**: An AYUSH Hospital is a healthcare facility wherein medical/surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
    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 the insurance company's authorized representative

9. *__AYUSH Day Care Centre:__ 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 registered AYUSH Medical Practitioner(s) 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 the insurance company's authorized representative.

10. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

11. **Cashless Facility** means a facility extended by the Insurer to the insured 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 approved.

12. **Claims Team** means the Claims administration team within Chola MS General Insurance Company.

13. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

14. **Congenital Anomaly** means a condition 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.

15. **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.

16. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

17. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/ her independent sources of income.

18 . **Dependents** refer to family members comprising of Spouse, Dependent Children, Parents, Parents-in-law, and Siblings who is financially dependent on the Primary Insured or proposer and does not have his / her independent sources of income.

19. **Diagnosis** means the identification of a disease/illness/medical condition made by a Medical Practitioner supported by clinical, radiological and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to us.

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

21. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with 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-

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

22. **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.

23. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

24. **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.

25. **Domiciliary Hospitalisation** 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:
    a. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b. The patient takes treatment at home on account of non-availability of room in a hospital.

26. **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.

27. **Endorsement** means written evidence of change to the insurance Policy including but not limited to increase or decrease in the policy period, extent and nature of the cover agreed by the Company in writing.

28. **Excluded hospital** means any hospital which is excluded from the hospital list of the company, due to fraud or moral hazard or misrepresentation indulged by the hospital.

29. **Family Floater** means a Policy described as such in the Schedule where You and Your Dependents named in the Schedule are insured under this Policy. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period.

30. **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 installments during the policy period.

31. **Hospital** means any institution established for inpatient care and day care treatment of illness 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:
    - has qualified nursing staff under its employment round the clock;

- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

32. **Hospitalisation** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

33. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

    a. **Acute condition** is 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** is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires rehabilitation for the patient or for the patient to be specially trained to cope with it—it continues indefinitely—it recurs or is likely to recur.

34. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

35. **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.

36. **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.

37. **ICU Charges** (Intensive Care Unit) charges means the amount charged by a Hospital towards ICU expenses 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.

38. **Identification or ID** card means the card issued to You by us.

39. **Inception Date** means the commencement date of the coverage under this Policy as specified in the Policy Schedule.

40. **Long Term** means the continuous period of insurance more than 12 months with in the Policy period.

41. **Maternity Expenses** means
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization)
    b. Expenses towards lawful medical termination of pregnancy during the policy period.

42. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

43. **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.

44. **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 its scope and jurisdiction of license.

    The registered Practitioner should not be the insured or close family members of the insured.

45. **Medically necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    a. is required for the medical management of the illness or injury suffered by Insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a medical practitioner;
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

46. **Membership Number** means an identification number of every insured person for our In-house Claims administration team. Membership number will be mentioned in the health card provided to each insured person.

47. **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.

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

49. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

50. **Non - Network** means any hospital, day care centre or other provider that is not part of the network.

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

52. **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.

53. **Pre-existing Disease 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 or
    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.

54. **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.

55. **Post-Hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of 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

56. **Policy** means the policy schedule (including endorsements if any), the terms and conditions in this document, any annexure thereto (as amended from time to time) and your statements in the Proposal form.

57. **Policy period** means the period between the commencement date and earlier of
    a. The Expiry Date specified in the Schedule.
    b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (7.14) below.
    c. In a multi Tenure Policy, a policy year would be reckoned from the date of inception to 12 months of continuous cover.

58. **Policy Schedule** means that portion of the Policy which sets out Your personal details, the type and plan of insurance cover in force, the Policy duration and sum insured etc. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.

59. **Proposal Form** The form in which the details of the insured person are obtained for a Health Insurance Policy. This also includes information obtained over phone or on the

internet and stored on any electronic media and forms basis of issuance of the policy

60. **Proposer** means the person who has signed in the proposal form and named in the Policy Schedule. He may or may not be insured under the policy.

61. **Pre-Hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of 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.

62. **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.

63. **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.

64. **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.

65. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

66. **Schedule of Benefits** means the table of benefits, with the limit of Sum Insured under each benefit, that will be paid by us as per the plan opted by you.

67. **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.

68. **Sum Insured** means the amount shown in the policy schedule which shall be our maximum liability under the policy. In relation to individual policy 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 and in relation to a Family Floater it is our maximum liability for any and all claims made by You and all of Your Dependents during the Annual Period (i.e., per annum for multi year tenure) within the Policy Period.

69. **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 center by a medical practitioner

70. **Unproven/Experimental treatment** means the treatment including drug Experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

C. List of Critical Illness and their definitions

1. **Cancer of Specified Severity**

   A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy . The term cancer includes leukemia, lymphoma and sarcoma.

   The following are excluded –

   a. All tumours which are histologically described as carcinoma in situ ,benign, pre-malignant, borderline malignant, low malignant potential,neoplasm of unknown behavior, or non-invasive,including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.

   b. Any non- melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond

   c. Malignant melanoma that has not caused invasion beyond the epidermis.

   d. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

   e. All thyroid cancers histologically classified as T1NOMO(TNM Classification) or below

   f. Chronic lymphocyctic leukaemia less than RAI stage 3

   g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification

   h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. **Stroke Resulting In Permanent Symptoms**

   I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

   II. The following are excluded:

      i. Transient ischemic attacks (TIA)

      ii. Traumatic injury of the brain

      iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

3. **Myocardial Infarction (First Heart Attack - of Specified Severity)**

   I. The first occurrence of heart attack or myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction will be evidenced by all of the following criteria:

      a. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

      b. New characteristic electrocardiogram changes

      c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

   II The following are excluded:

      i. Other acute Coronary Syndromes

      ii. Any type of angina pectoris

      iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-cardiac procedure.

4. **Open Chest CABG**

   I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

   II. The following are excluded:

      i. Angioplasty and/or any other intra-arterial procedures

5. **Kidney Failure Requiring Regular Dialysis**

   I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

6. **Multiple Sclerosis With Persisting Symptoms**

   I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

      i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

      ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

   II. Neurological damage due to SLE is excluded.

7. **Major Organ / Bone Marrow Transplant**

    I. The actual undergoing of a transplant of:

        i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

        ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

    II. The following are excluded:

        i. Other stem-cell transplants

        ii Where only islets of langerhans are transplanted

8. **Permanent Paralysis of Limbs**

    I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

9. **Primary (Idiopathic) Pulmonary Hypertension**

    I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

    II. The NYHA Classification of Cardiac Impairment are as follows:

        i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

        ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

    III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

10. **Motor Neuron Disease with Permanent Symptoms**

    I Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. **Open Heart Replacement or Repair of Heart Valves**

    I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an electrocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

12. **Coma of Specified Severity**

    I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

        i. no response to external stimuli continuously for at least 96 hours;

        ii. life support measures are necessary to sustain life; and

        iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

    II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

13. **Surgery to Aorta**

    The actual undergoing of surgery for a disease of the aorta (meaning the thoracic and abdominal aorta but not its branches, and excluding traumatic injury of the aorta and congenital narrowing of the aorta) needing excision and surgical replacement of the diseased aorta with a graft

14. **Parkinson's Disease**

    The unequivocal diagnosis of progressive degenerative idiopathic Parkinson's disease by a consultant Neurologist. This diagnosis must be supported by all of the following conditions:

    a. The disease cannot be controlled with medication;
    b. Sign s of progressive impairment; and
    c. Inability of the insured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months

    Activities of Daily Living:

    I. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

    II. Dressing: the ability to put on, take-off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

    III. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa

    IV. Mobility: the ability to move indoors from room to room on level surfaces;

    V. Toileting: the ability to use the lavatory or otherwise manage bowel

and bladder functions so as to maintain a satisfactory level of personal hygiene;

VI. Feeding: the ability to feed oneself once food has been prepared and made available.

Exclusions: Drug induced or toxic causes of Parkinsonism are excluded

2. SCHEDULE OF BENEFITS

Benefits in the table below should be read in conjunction with Section 3 Coverages and Section 1 Definitions

S.No.	Plans	Value Healthline	Freedom Healthline	Enrich Healthline	Privilege Healthline
	Sum Insured (In Lakhs)	Rs 1/2/3/5/7.5/10	Rs 2/3/5/7.5/ 10/15	Rs 3/5/7.5/10/ 15/20/25	Rs 5/7.5/10/ 15/20/25
Benefits forming part of Sum Insured opted					
A	In –Patient Hospitalization Expenses	Covered	Covered	Covered	Covered
B	Day Care Procedures / Treatment Expenses	Covered	Covered	Covered	Covered
C	Pre Hospitalization Expenses	30 days	60 days	60 days	60 days
D	Post Hospitalization Expenses	60 days	90 days	90 days	90 days
E	Domiciliary Hospitalization Expenses per insured person per policy year	Max 7 days	Max 7 days	Max 7 days	Max 7 days
F	AYUSH Coverage Expenses	Covered	Covered	Covered	Covered
G	Organ Donor Hospitalization Expenses	Covered	Covered	Covered	Covered
H	Emergency Ambulance Expenses per Hospitalization	Rs 1000	Rs 2000	Rs 2000	Rs 5000

I	Maternity Expenses (Upto 2 deliveries , after 3 consecutive renewals)	NO	NO	NO	Upto Rs 1 Lakh Per delivery
J	New Born Baby Hospitalization Expenses	NO	NO	NO	Covered upto Sum Insured of Mother / Floater Sum Insured
K	Co-payment for age above 55 years	10% on all claims	NO	NO	NO

Additional Benefits over the Sum Insured					
A	Child Hospitalization Allowance per hospitalization	NO	NO	Rs 500 per day for 7 days	NO
B	Outpatient Dental/ Specs/ Contact lens/hearing aids	NO	NO	NO	Rs 10000 every 2 years
C	Extended Hospitalization Allowance (Minimum 10 days Hospitalization)	NO	NO	Rs 10,000	Rs 10,000
D	Double Sum Insured	NO	NO	For Critical illness and Accidents	For Critical illness and Accidents
E	Specialist Opinion for Critical illness	NO	NO	NO	Rs 25000/-

S.No.	**Plans**	**Value Healthline**	**Freedom Healthline**	**Enrich Healthline**	**Privilege Healthline**
Renewal Benefits					
A	Health Checkup Expenses	NO	Once after 3 claim free years	Once after 2 claim free years	Once after 2 claim free years

S.No.	Plans	Value Healthline	Freedom Healthline	Enrich Healthline	Privilege Healthline
Renewal Benefits					
B	Cumulative Bonus	5% of Sum Insured every claim free year subject to maximum of 25% of Sum Insured	5% of Sum Insured every claim free year subject to maximum of 50% of Sum Insured	50% of Sum Insured every claim free year subject to maximum of 100% of Sum Insured	5% of Sum Insured every claim free year subject to maximum of 50% of Sum Insured
C	Reduction in Cumulative Bonus	5% of Sum Insured	5% of Sum Insured	50% of Sum Insured	5% of Sum Insured

- Single occupancy AC room is allowed for all Sum Insured except for Rs 1 Lakh/2 Lakhs. For Rs 1 Lakh/2 Lakhs Sum Insured the maximum room rent allowed is Rs 1500 and Rs 3000 per day, respectively.
- In the event of Insured occupying a higher room category than the eligibility under the plan opted, differential room rent would be deducted from the claim amount.
- In the case of Family floater policy, the benefits shown in the table above will represent our maximum liability for any and all claims made by Insured person(s) during the policy period.
- Under **Value Healthline plan**, a co-payment of 10% on all claims will be applicable for Insured Persons above 55 years of age.
- A **Co-payment** of 10% shall be applied on each and every admissible claim in case of treatment taken in a hospital from Tier 1 location and the premium has been paid for Tier 2 location
- Maximum Renewal age for dependent children is 26 years. On renewal, such insured person shall be ported into a separate Health policy with continuity benefits

3. COVERAGES

Upon the happening of the events under sections 3.1 and 3.2 below during the policy period, we will indemnify the policyholders in respect of medically necessary costs as detailed below, up to the limit of Indemnity defined in the schedule of benefits and as per the General Conditions in Section 6 of this policy.

3.1 Benefits forming part of Sum Insured opted

3.1.1 Inpatient Hospitalization Expenses

We will pay for hospitalization expenses that require more than 24 hrs of Hospitalization for illness or accidental bodily injury upto Sum insured mentioned in the policy schedule:

a. Room and Boarding

b. Doctors fees

c. Intensive Care Unit charges
d. Nursing Expenses
e. Surgical fees, operating theatre, anaesthesia and oxygen and their administration
f. Physical therapy expenses
g. Drugs and medicines consumed on the premises
h. Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, diagnostic tests)
i. Cost of dressing, ordinary splints and plaster casts
j. Costs of prosthetic devices if implanted during a surgical procedure

3.1.2 **Day Care Procedures/Treatment Expenses**

We will pay for Medical Expenses incurred in a Day Care Procedure/Treatment that requires less than 24 hours of hospitalisation, upto Sum Insured mentioned in the policy schedule, if it is performed in a network hospital. In case the procedure is performed in a non network hospital, the same must be pre-authorised by us. Pre-authorisation has to be obtained 72 hours prior to the date of admission in case of planned admission and within 24 hours in case of emergency admission.

3.1.3 **Pre-Hospitalization Expenses**

We will pay for medical expenses incurred immediately before the Insured Person is Hospitalized upto the number of days mentioned in the schedule of benefits, provided that

a. The expenses were incurred after the first 30 day waiting period as mentioned in Exclusion no 4.iii
b. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
c. The Inpatient Hospitalization claim for such Hospitalization is admissible by us.

3.1.4 **Post-Hospitalization Expenses**

We will pay for medical expenses incurred immediately after the Insured Person is discharged upto the number of days mentioned in the Schedule of benefits, provided that

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The Inpatient Hospitalization claim for such Hospitalization is admissible by us.

3.1.5 **Domiciliary Hospitalisation Expenses:**

We will pay for expenses towards domiciliary hospitalisation provided that the condition for which the medical treatment is required continues for at least 2 days, in which case the Policy pays reasonable cost of any necessary medical treatment for a maximum of 7 days per insured person in a policy year. This benefit is applicable for each Insured person in a family floater policy. Pre-hospitalisation

and Post hospitalisation expenses in accordance with Section 3.1.3 and 3.1.4 will be covered under this benefit.
Cashless facility will not be available for such a claim.

3.1.6 *__AYUSH Coverage Expenses__

This policy will pay for Hospitalisation expenses that require more than 24 hours of Hospitalisation and Day care procedures for illness or accidental bodily injury for non-allopathic treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems upto Sum insured stated in the policy schedule. The treatment should have been undergone in AYUSH Hospital / AYUSH Day care centre as defined in the policy.

3.1.7 **Organ Donor Hospitalisation Expenses**

We will pay for medical expenses incurred on a legal Organ Donor's treatment for the harvesting of the organ donated. We will not pay for Donor's pre and post Hospitalisation expenses or any other medical treatment consequent to the harvesting.

3.1.8 **Emergency Ambulance Expenses**

We will pay for ambulance expenses, as mentioned in the Schedule of benefits, incurred to transfer the insured person following an emergency to the nearest Hospital with adequate facilities, provided that:

i. The ambulance service is offered by a healthcare or an ambulance service provider
ii. We have accepted the inpatient hospitalization claim under point 3.1 above.

3.1.9 **Maternity Expenses (Available in Privilege Healthline Plan only after 36 months Waiting period):**

We will pay for medical expenses for delivery (including caesarean section) or the lawful medical termination of pregnancy, (without threat to mother or child's life) while Hospitalised, during the policy period excluding elective termination, limited to 2 deliveries or terminations or either one of each during the lifetime of the Insured. This will include pre-natal and post-natal expenses per delivery or termination and medically necessary treatment of the new born baby within the policy period provided that maximum liability per delivery or termination shall be limited to the amount specified in the Schedule of Benefits.

This benefit will be paid only after three consecutive renewals without a break.

3.1.10 **Newborn Baby Cover:**

We will pay for the Hospitalization expenses for a new born baby, from the day of birth to 90 days, provided that it is following a valid claim under maternity expenses for an insured mother. The new born baby will be covered within the Sum Insured of the mother in case the policy is on Individual Sum Insured basis. In case of family floater policy, the floater sum insured will be the maximum limit for this benefit.

The total amount payable under the policy per year for all sub sections under 3.1 as above put together shall not exceed the sum insured for you shown in the policy schedule.

3.2 **Additional Benefits over the Sum Insured**

3.2.1 **Child Hospitalization Allowance per hospitalization**

We will pay an allowance for the accompanying adult if an Insured child aged 18 yrs or less is hospitalized for more than 24 hours. The maximum limit under this benefit is as mentioned in the schedule of benefits. For a claim to be admissible under this benefit, we should have accepted an inpatient Hospitalization claim under Section 3.1.1 above.

3.2.2 **Outpatient Dental / Specs/Contact lens/hearing aids**

We will pay for the cost of Dental treatments, spectacles or contact lens or a hearing aid, (excluding batteries) subject to a maximum limit as mentioned in the Schedule of benefits, provided that.

a. It should be prescribed by the Medical Practitioner.
b. The prescription of the Medical Practitioner and the bills/receipts/ invoices are necessary for making a claim
c. The benefit limit is available once in a block of two policy years irrespective of the tenure of the policy and the number of claims made.

This benefit cannot be carried forward if unutilized in the eligible policy year.
Cashless facility will not be available for such a claim.

Your cumulative bonus earned will not reduce if a claim is made under this benefit.

3.2.3 **Extended Hospitalization Allowances**

We will pay an allowance as mentioned in the schedule of benefits, if the insured person is hospitalised for 10 continuous days, in case the policy is on Individual Sum Insured basis. In case of family floater, the limits mentioned in this benefit in the schedule of benefit will represent our maximum liability for any and all claims made by Insured person(s) during the policy period.

3.2.4 **Double Sum Insured**

In the event of the Insured Person under Enrich and Privilege Healthline Plans of this Policy, being diagnosed with a Critical Illness or/and requiring Hospitalization due to accidental bodily Injury, if the Sum Insured is exhausted or not sufficient and a claim has been admitted by us in the policy year, an additional Sum insured equivalent to the policy Sum insured excluding cumulative bonus will be made available for claims. The additional Sum insured hence available can only be used for admissible claims in the same policy year arising out of Critical Illnesses or for Accidental Bodily Injury as defined in this policy.

This Benefit is available for occurrence of Critical Illnesses upto 65 yrs of age of Insured person.

The total claim(s) payable will in any case not exceed twice the Sum Insured and Cumulative bonus as mentioned in the policy schedule put together. The double Sum Insured is applicable only for the current policy year and any unused Sum Insured cannot be carried forward to the next policy year. The policy does not cease on payment of claim under this benefit.

3.2.5 **Specialist Opinion for Critical Illnesses**

We will pay the cost of opinion from a specialist doctor in the event of occurrence of any of the critical illnesses as defined in **Section 1 C - List of Critical Illness and their definitions**, upto the limits defined in the schedule of benefit. This benefit will be enforceable only if a valid hospitalization claim has been admitted for a critical illness. This will not cover cost of additional tests, diagnostic reports etc. This can be availed once in a policy period (per annum in case of multi-year tenure). In the case of Family floater policy, the benefit mentioned in the schedule of benefits will represent our maximum liability for any and all claims made by Insured person(s) during the policy period. Cashless facility will not be available for such a claim..

3.2.6 **Co-Payment**

In case the insured has availed treatment in a hospital from Tier 1 location and the premium has been paid for Tier 2 location , then a co-payment of 10% shall be applied on each and every admissible claim

This Co-payment shall not be applicable to any claim under sections-3.2.1 Child Hospitalisation Allowance per Hospitalisation,3.2.2 Outpatient Dental/Specs/ Contact lens /hearing aids, 3.2.3 Extended Hospitalization Allowance, 3.2.5 Specialist Opinion for Critical Illness

3.2.7 **Health Check-up**

All insured persons under the Freedom, Enrich and Privilege Healthline Plans of this policy will be eligible for a General Health Check Up after two/three continuous claim free policy years as mentioned in the schedule of benefits.

a. Pre-authorization is taken from us for undergoing such medical check-up.
b. The medical checkup is carried out in a Hospital / Diagnostic Centre suggested by us.
c. In case of family floater policy,
    i. All the members of a family floater policy are eligible for a Health Check up.
    ii. If any of the members have made a claim under this Policy, the health check-up benefit will not be offered under the policy for any members.

The list of Health Check-ups eligible under respective plans is placed at **Annexure 1**

Your cumulative bonus earned will not reduce if a claim is made under this benefit.

3.2.8 **Cumulative Bonus**

If the insured has not made a claim in a policy year (per annum in case of multi-year tenure) and has renewed the policy with us without a break, we will increase your Sum Insured under each subsequent policy by a percentage of the expiring policy Sum Insured as mentioned in the schedule of benefits. The maximum cumulative bonus shall at no time exceed 100% of the policy Sum Insured. In the case of Individual Sum Insured, the cumulative bonus will be applicable to all family members who have not made a claim during the expiring policy year. In the case of a floater Sum Insured, cumulative bonus will applicable only if none of the family members have made a claim under the previous policy year.

In case of Multi year tenure, any increase in the cumulative bonus will be determined at the start of every new policy year and the same will be reflected on the policy schedule only at the time of renewal of the policy.

3.2.9 **Reduction in Cumulative Bonus**

In the event of a claim during a policy year (per annum in case of multi-year tenure), the claim free bonus in any subsequently renewed policies shall be reduced by a percentage as mentioned in the schedule of benefit. Such a reduction will be made ensuring that the limit of Indemnity shall not fall below 100% of the Basic Sum insured available under expiring policy with us.

In case of multi year tenure, any decrease in the cumulative bonus will be determined at the start of every new policy year and the same will be reflected on the policy schedule only at the time of renewal of the policy.

4. WAITING PERIOD

i. 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 insurer.

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 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 Insurer

ii. Specified disease/procedure waiting period – Code – Excl02:

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

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

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

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

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

f) List of specific diseases/procedures are as below

a. Congenital Internal Diseases, (except for the coverage extended under New Born Baby Cover)
b. Varicose veins and Varicose Ulcers
c. Rheumatism and arthritis of any kind
d. Treatment of diseases on ears/ tonsils /adenoids /paranasal sinuses / Deviated Nasal Septum
e. Stones in the Urinary and Biliary systems
f. Gastric or Duodenal Ulcer
g. Any type of benign Cyst/ Nodules/ Polpys/ Tumours/ Breast Lumps
h. Intervertebral Disc Prolapse, and Degenerative Disc / vertebral Disorders
i. Cataract
j. Benign Prostatic Hypertrophy
k. Myomectomy, Hysterectomy unless because of malignancy
l. Dilatation and curettage (D&C)
m. Anal Fistula, Fissure and Piles
n. All types of Hernia
o. Hydrocele
p. Chronic Renal Failure
q. Joint replacement Surgery unless because of accident

iii. 30-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.

5. GENERAL EXCLUSIONS

The policy does not cover any losses caused directly due to the following:

1. I**nvestigation & Evaluation – Code–Excl 04:**

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

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

2. **Rest, Cure, Rehabilitation and Respite Care – Code–Excl 05:**

   a. Expenses related to any admission primarily for enforced bed-rest and not for receiving treatment. This also includes:

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

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

3. **Obesity/Weight Control: Code–Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

   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 Type 2 Diabetes

4. **Change-of-gender Treatments:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. **(Code–Excl 07)**

5. **Cosmetic or Plastic Surgery**: 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. **(Code–Excl 08)**

6. **Hazardous or Adventure Sports:** 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. **(Code–Excl 09)**

7. **Breach of Law:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. **(Code–Excl 10)**

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.

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

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–Excl 13)**

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

12. **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **(Code–Excl 15)**

13. **Unproven Treatments :** 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. **(Code–Excl 16)**

14. **Sterility and Infertility: Code–Excl 17:** 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

15. **Maternity Expenses: Code–Excl 18:** (Except to the extent provided in the Privilege Health Line Plan)
    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.

16. War or any act of war, invasion, acts of foreign enemies, hostilities whether are be declared or not, civil war, revolution, insurrection, mutiny, martial law

17. Intentional self-injury or attempted suicide whether sane or insane.

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

19. Any travel or transportation costs or expenses excluding ambulance charges

20. Circumcisions (unless necessitated by illness or injury and forming part of treatment)

21. Vaccination or inoculation unless forming a part of post-animal bite treatment

22. Sexually transmitted disease or illness

23. Durable medical equipment (including but not limited to wheelchairs, crutches, artificial limbs and the like), (namely that equipment used externally from the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose; is generally not useful in the absence of a Illness or Injury and is usable outside of a Hospital) unless required for the treatment of Illness or Accidental Bodily Injury. The Items as mentioned above may be amended as per the schedule of benefits being attached to the policy

24. Any external congenital diseases, defects or anomalies.

25. Except to the extent provided in the Schedule of Benefit, any dental treatment or surgery of a corrective, cosmetic or aesthetic nature unless it requires hospitalisation and is carried out under general anesthesia and is necessitated by Illness or Accidental Bodily Injury

26. Except to the extent provided in the Schedule of Benefit, any expenses towards hearing aids, eyeglasses or contact lenses

27. Independent personal comfort and convenience items or services which are non-medical in nature and are charged separately unless they form part of the room rent.

28. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of the Insured Person's family

29. Any condition after the point at which it is certified by the attending doctor to be of such a nature that further medical treatment may serve to stabilize or maintain it but is unlikely to result in a material improvement within a reasonable timeframe.

30. Treatment other than Allopathy and AYUSH*.

31. Non medical Expenses incurred during Hospitalisation. The list of such Non medical Expenses is placed at **Annexure 2**.

6. GENERAL CONDITIONS

6.1. Condition Precedent to Admission of Liability

The terms and Conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

6.2. 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

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.

6.3. 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.

6.4. 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 by the policyholder.

(Explanation: “Material facts” for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6.5. **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 and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an 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; and
d. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6.6. **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. 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.

6.7. **Multiple Policies**

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person 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 chosen by the insured person 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.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the Primary Insurer 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.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

This clause is not applicable for fixed benefit sections of the policy – Additional Benefit (A), (B), (C) and (E) and Renewal Benefit (A).

6.8. **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 case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 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.

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

(Explanation: “Bank rate” shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

6.9. **Complete Discharge**

Any payment to the policyholder, insured person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6.10. **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. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

6.11. **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.

6.12. **Withdrawal of the Product**

i. 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.

ii. 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.

6.13. **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.

6.14. **Cancellation of cover**

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.

6.15. **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.

6.16. **Change of Address/Contact Details**

It is in the Insured person's interest to intimate us if there is any change in residential address and phone numbers.

6.17. **Cost of Pre Insurance Health Check up**

Pre Policy Health Check up for the proposed customers will be arranged by our Designated Service Provider on Cashless basis.

No cost will be collected from the Customers towards the same.

In case after undergoing the Pre Policy Health Check up, the Proposal gets rejected by us or Insured decides not to take the policy, the expenses incurred by the Insurer for the purpose of Pre Policy Health Check up may be deducted from the Insured's premium and the balance premium would be refunded.

6.18. **Specific Exclusions**

a. A specific exclusion with waiting period may be applied on a medical condition/ disease depending on the medical test done based on the Proposed Insured person's medical history and declarations as part of special conditions on the Policy with due consent from the policyholder.

6.19. **Notification**

i. 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 respectively specified in the Schedule.

ii. 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 Schedule.

6.20. **Transfer**

Transferring of interest in this Policy to anyone else is not allowed.

6.21. **Governing Law**

The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are descriptive only and do not form part of this Policy for the purpose of its construction or interpretation.

6.22 **Entire Contract**

The Policy constitutes the complete contract of insurance. Only the Insurer may alter the terms and conditions of this Policy. Any alteration that may be made by the Insurer shall be evidenced by a duly signed and sealed endorsement on the Policy.

6.23. **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.

6.24. **Assignment**

The policy can be assigned subject to applicable laws.

6.25. **Claim Procedure**

A. Hospitalisation Claim

a. 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, or require a Day Care Procedure, then it is a condition precedent to our liability that You shall immediately:

a. Give us intimation of the claim irrespective of intimation 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.

Type of hospitalization	Claim Intimation - 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

b. Procedure for Cashless Claims

Obtain our pre-authorisation for any medical treatment in any of our network hospitals as well as identified list of hospitals by GIC for common empanelment through anywhere cashless facility. Insured can view or download the updated Hospital Network from the Company's website www.cholainsurance.com as well as Chola MS mobile application

In case of planned admission, pre-authorisation has to be obtained 72 hours prior to the date of admission and within 48 hours of an emergency admission. Pre-authorisation request shall, if we are satisfied as to the validity of the claim, specify:

1. The treatment authorised;
2. The place at which it has been authorised, and
3. Any other conditions applicable to either.

c. Procedure for submission of Reimbursement Claims

1. Upon Hospitalisation, the insured Person or his/her dependents shall provide us with fully particularised details of the quantum of any claim to be reimbursed and any and all other information and documentation in respect of the claim and/or our liability for it sought by our In-House Claims team at the earliest possible opportunity not exceeding 30 days from date of discharge.
2. We shall be under no obligation to pay or arrange to make payment for any claim until and unless it is satisfied as to the validity and quantum of Your claim.
3. The Insured shall obtain and furnish to the Company all copy of bills, receipts and any other documentation upon which a claim is based. `Except in cases

where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The expenses towards doctors' fees for any additional medical examination required by us, at the time of claim shall be borne by us.

4. We shall only make payment (unless already paid direct to the service provider/hospital) to You or your Nominee.

5. You acknowledge and agree that the payment of any claim by or on behalf of us shall not constitute on the part of us any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by You, it being agreed and recognised by You that we are not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution (including a Network Hospital) whether pre-authorised or not.

d. Claim Documentation:

Following documents are to be submitted for processing of the claim along with the duly filled & signed claim form by the insured / nominee in addition to the documents listed in the table:

- KYC of the Insured and KYC of the nominee / legal heir in case of death claim under the policy.
- Account details with proof for NEFT of the Insured and of nominee / legal heir in case of death claim under the policy i.e. cancelled cheque, passbook copy has to be submitted with the below listed claim documents.
- Proof of identity and residence of the beneficiary for claims exceeding Rs.1 Lakh

Covers	Documents

In-Patient Hospitalization Expenses /AYUSH /Day care Procedure/	Original Discharge summary in the hospital letter head with the seal and sign of the doctor with complete details of diagnosis, treatment given, treatment advised etc. Original Main bill from the hospital with cost wise break up Original payment receipt (Receipt should have Serial No) Original investigation reports (such as X Ray, Lab Reports, Scan reports etc.) These are required for supporting the ailment, hence all reports taken prior / at the time or after the hospitalization are required All pharmacy bills should be accompanied with relevant prescriptions. Bills should contain date and patient name. If pharmacy is charged in the Main Hospital bill, then proper itemized break up of those medicines should be obtained from the hospital. Implant stickers or invoice where ever applicable In case of Road traffic accident (RTA), copy of FIR and/or Medico legal Certificate (MLC) would be required.

TPA - There is no TPA tie –up envisaged for this product. Any arrangement in future will be disclosed in the Policy to the Policyholders.

Chola MS customer support operates 24/7 basis and the contact details are as followed for any queries / grievances:

- Toll Free Phone No: 1800-208-9100
- E-Mail: customercare@cholams.murugappa.com

Address of Chola MS Health Claims Office:

Cholamandalam MS General Insurance Company Limited

Chola MS HELP – Health Claims Department

New No.2, Old No. 234, Parry House

3rd Floor, N. S. C. Bose Road

Chennai - 600001

Customer Care Toll Free No: 1800-208-9100

E-Mail: customercare@cholams.murugappa.com

e) **Chola MS Excluded Hospitals:** Please refer our website www.cholainsurance.com or Chola MS app for latest list of excluded hospitals of Chola MS, as we will not consider / pay any claim from these hospitals. However, in case of life-threatening situations or following an accident, expenses incurred for the treatment up to the stage of stabilization are payable but not the complete claim. For more details call us at 1800-208-9100 or Mail: customercare@cholams.murugappa.com

6.26. **Delay in intimation of claim**

It is essential and imperative that any loss or claim under the policy has to be intimated within the timelines to us strictly as per the policy conditions to enable us to appoint investigator for loss assessment. This will enable us to render prompt service by way of quick and fair settlement of claim, which is our primary motto. Any genuine delay, beyond Your control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Your end and especially if the delay has hindered conducting investigation on time to make proper assessment, to mitigate further loss, if any may not only delay the claim settlement but also may result in claim getting rejected on merits.

6.27. **Authority to obtain records**

The insured must procure and cooperate with us in procuring any medical records and information from the hospital relating to the treatment for which claim has been lodged. If required, the Insured Person should give consent to us to obtain Medical records / opinion from the Hospital directly relating to the treatment for which claim has been made.

If required the Insured / Insured Person must agree to be examined by a Medical Practitioner of Company's choice at our expense.

6.28. **Any one illness/ relapse period**

If the hospitalization is continuous and the illness relapses within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken will be treated as same illness.

6.29. **Sum Insured Enhancement**

Sum Insured can be enhanced only at the time of renewal subject to reported claim status and health condition of the insured. If you decide to increase the sum insured at the time of renewal, subject to our acceptance, then the coverage for the increased sum insured shall be as if a new policy is issued for the additional sum insured. The additional Sum Insured will be available subject to 30 day, 2 years and 4 years waiting period as per waiting periods in section 5 above.

6.30. **Disclaimer**

It is also hereby further expressly agreed and declared that if we shall disclaim liability to You for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a Court of law or pending reference before Ombudsman, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

7. GRIEVANCES

7.1 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

Fax : 044-4044 5550

Courier :Manager, Customer Care,
Chola MS General Insurance Company Limited
Hari Niwas 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.

Office Details	Jurisdiction of Office
AHMEDABAD - Shri Kuldip Singh, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU – Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 I 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
BHOPAL- Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar - 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa

CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI -600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: ,bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI- Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD- Office of the Insurance Ombudsman, 6-2-46, 1st floor, “Moin Court”, Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry

JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA- Shri P.K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R.Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/ 28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi. co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 I 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA- Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune- 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

ANNEXURE - 1 (attached to and forming part of policy wordings)
List of Free Health Check-ups Eligible as per plan opted

Check -ups Eligible	Freedom Healthline Plan (Once after 3 claim free years)	Enrich Healthline Plan (Once after 2 claim free years)	Privilege Healthline Plan (Once after 2 claim free years)
MER	✓	✓	✓
CBC	✓	✓	✓
ECG	✓	✓	✓
CUE	✓	✓	✓
FBS	✓	✓	✓
LFT	✓	✓	✓
RFT			✓
CXR			✓
Lipid Profile			✓
USG			✓
TMT			✓

a. MER – Medical Examination Report

b. CBC – Complete blood Count

c. ECG – Electro Cardio Gram

d. CUE – Complete Urine Examination

e. FBS – Fasting Blood Sugar

f. LFT – Liver Function Test

g. RFT – Renal Function Test

h. CXR – Chest X-Ray

i. Lipid Profile

j. USG – Ultra Sono Gram

k. TMT – Treadmill Test

ANNEXURE - 2 (attached to and forming part of policy wordings)

List of Non-Medical Expenses excluded in this Policy

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	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/SHORT/HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
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 (DELIVERY KIT, ORTHO KIT, 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	TOOTHPASTE
13	TOOTHBRUSH
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	PULSE OXIMETER CHARGES
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, HARMONIC SCALPEL, 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	TOURNIQUET
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	ALCOHOL SWABS
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

List of Day Care Procedures

Operations on the ears	
Sl no	**Microsurgical operations on the middle ear**
1	Stapedotomy
2	Stapedectomy
3	Revision of a Stapedectomy
4	Other operations on the auditory ossicles
5	Myringoplasty (Type I tympanoplasty)
6	Tympanoplasty (closure of an eardrum perforation and reconstruction of the auditory ossicles)
7	Revision of a tympanoplasty
8	Other microsurgical operations on the middle ear
Other operations on the middle and internal ear	
9	Paracentesis (myringotomy)
10	Removal of a tympanic drain
11	Incision of the mastoid process and middle ear
12	Mastoidectomy
13	Reconstruction of the middle ear
14	Other excisions of the middle and inner ear
15	Fenestration of the inner ear
16	Revision of a fenestration of the inner ear
17	Incision (opening) and destruction (elimination) of the inner ear
18	Other operations on the middle and inner ear

Operations on the nose and the nasal sinuses	
19	Excision and destruction of diseased tissue of the nose
20	Operations on the turbinates (nasal concha)
21	Other operations on the nose
22	Nasal sinus aspiration
Operations on the eyes	
23	Incision of tear glands
24	Other operations on the tear ducts
25	Incision of diseased eyelids
26	Excision and destruction of diseased tissue of the eyelid
27	Operations on the canthus and epicanthus
28	Corrective surgery for entropion and ectropion
29	Corrective surgery for blepharoptosis
30	Removal of a foreign body from the conjunctiva
31	Removal of a foreign body from the cornea
32	Incision of the cornea
33	Operations for pterygium
34	Other operations on the cornea
35	Removal of a foreign body from the lens of the eye
36	Removal of a foreign body from the posterior chamber of the eye
37	Removal of a foreign body from the orbit and eyeball
38	Operation of cataract
Operations on the skin and subcutaneous tissues	
39	Incision of a pilonidal sinus
40	Other incisions of the skin and subcutaneous tissues
41	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin
42	Removal of subcutaneous tissues
43	Local excision of diseased tissue of the skin and subcutaneous tissues
44	Other excisions of the skin and subcutaneous tissues
45	Simple restoration of surface continuity of the skin and subcutaneous tissues
46	Free skin transplantation, donor site
47	Free skin transplantation, recipient site
48	Revision of skin plasty
49	Other restoration and reconstruction of the skin and subcutaneous tissues

50	Chemosurgery to the skin
51	Destruction of diseased tissue in the skin and subcutaneous tissues
Operations on the mouth and face	
Operations to the tongue	
52	Incision, excision and destruction of diseased tissue of the tongue
53	Partial glossectomy
54	Glossectomy
55	Reconstruction of the tongue
56	Other operations on the tongue
Operations on the salivary glands and salivary ducts	
57	Incision and lancing of a salivary gland and a salivary duct
58	Excision of diseased tissue of a salivary gland and a salivary duct
59	Resection of a salivary gland
60	Reconstruction of a salivary gland and a salivary duct
61	Other operations on the salivary glands and salivary ducts
Other operations on the mouth and face	
62	External incision and drainage in the region of the mouth, jaw and face
63	Incision of the hard and soft palate
64	Excision and destruction of diseased hard and soft palate
65	Incision, excision and destruction in the mouth
66	Plastic surgery to the floor of the mouth
67	Palatoplasty
68	Other operations in the mouth
Operations on the tonsils and adenoids	
69	Transoral incision and drainage of a pharyngeal abscess
70	Tonsillectomy without adenoidectomy
71	Tonsillectomy with adenoidectomy
72	Excision and destruction of a lingual tonsil
73	Other operations on the tonsils and adenoids
Traumatological surgery and orthopaedics	
74	Incision on bone, septic and aseptic
75	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76	Suture and other operations on tendons and tendon sheath
77	Reduction of dislocation under GA

78	Arthroscopic knee aspiration
Operations on the breast	
79	Incision of the breast
80	Operations on the nipple
Operations on the digestive tract	
81	Incision and excision of tissue in the perianal region
82	Surgical treatment of anal fistulas
83	Surgical treatment of haemorrhoids
84	Division of the anal sphincter (sphincterotomy)
85	Other operations on the anus
86	Ultrasound guided aspirations
87	Sclerotherapy etc.
Operations on the female sexual organs	
88	Incision of the ovary
89	Insufflation of the Fallopian tubes
90	Other operations on the Fallopian tube
91	Dilatation of the cervical canal
92	Conisation of the uterine cervix
93	Other operations on the uterine cervix
94	Incision of the uterus (hysterotomy)
95	Therapeutic curettage
96	Culdotomy
97	Incision of the vagina
98	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99	Incision of the vulva
100	Operations on Bartholin's glands (cyst)
Operations on the male sexual organs	
Operations on the prostate and seminal vesicles	
101	Incision of the prostate
102	Transurethral excision and destruction of prostate tissue
103	Transurethral and percutaneous destruction of prostate tissue
104	Open surgical excision and destruction of prostate tissue
105	Radical prostatovesiculectomy
106	Other excision and destruction of prostate tissue

107	Operations on the seminal vesicles
108	Incision and excision of periprostatic tissue
109	Other operations on the prostate
Operations on the scrotum and tunica vaginalis testis	
110	Incision of the scrotum and tunica vaginalis testis
111	Operation on a testicular Hydrocele
112	Excision and destruction of diseased scrotal tissue
113	Plastic reconstruction of the scrotum and tunica vaginalis testis
114	Other operations on the scrotum and tunica vaginalis testis
Operations on the testes	
115	Incision of the testes
116	Excision and destruction of diseased tissue of the testes
117	Unilateral orchidectomy
118	Bilateral orchidectomy
119	Orchidopexy
120	Abdominal exploration in cryptorchidism
121	Surgical repositioning of an abdominal testis
122	Reconstruction of the testis
123	Implantation, exchange and removal of a testicular prosthesis
124	Other operations on the testis
Operations on the spermatic cord, epididymis und ductus deferens	
125	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126	Excision in the area of the epididymis
127	Epididymectomy
128	Reconstruction of the spermatic cord
129	Reconstruction of the ductus deferens and epididymis
130	Other operations on the spermatic cord, epididymis and ductus deferens
Operations on the penis	
131	Operations on the foreskin
132	Local excision and destruction of diseased tissue of the penis
133	Amputation of the penis
134	Plastic reconstruction of the penis
135	Other operations on the penis
Operations on the urinary system	
136	Cystoscopical removal of stones

Other Operations	
137	Lithotripsy
138	Coronary angiography
139	Haemodialysis
140	Cancer Chemotherapy
141	Radiotherapy for Cancer

8. Medical Second Opinion – Add on Cover

(on payment of additional premium)

UIN: CHOHLIA19048V011920

1. GENERAL CONDITION

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, 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 and Conditions of the Underlying Policy shall apply to the Add-on Cover.

2. COVERAGE

In the event of any Insured Person, being diagnosed with any Medical Condition during the Policy Year, he or she can obtain the Medical Second Opinion from the World's Leading Medical Centers (WLMC) tied up with our Service Provider.

On the basis of the Diagnosis, a choice of 3 world leading medical centers will be provided to the Insured, from which the Insured will have an option to select one center.

All the medical records pertaining to the Insured's diagnosis will be collected by the Service Provider from the Insured and will be submitted to the Clinical Team of the WLMC selected by him/her. The clinical team will review the medical records received by them and provide a detailed Medical Second Opinion to the Insured with recommendations.

2. a. Specific Conditions:

The coverage under this policy is subject to the following special conditions

1. This policy shall not provide medical second opinion in respect of illnesses for which the Insured member is undergoing treatment at the time of taking the policy.
2. Medical Second Opinion should be specifically requested for by the Insured.

3. The Insured is free to choose whether or not to obtain the Second Opinion and, if obtained under this cover, then whether or not to act on it.
4. This opinion is given based only on the medical records submitted without examining the patient, who is covered under the policy.
5. This benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured's visit or consultation to an independent Medical Practitioner.
6. Any Medical Second Opinion provided hereunder shall not be valid for any medico-legal purposes or any insurance claim purposes.
7. Medical Second Opinion under this cover is facilitated by the Service Provider from the WLMC and not provided by the Company.
8. The Company does not make any representation as to the adequacy or accuracy of the Medical Second Opinion or the Insured's or any other person's reliance on the same or the use to which the Second Opinion is put.
9. The Company is not liable for any claims due to any errors or omission or consequences of any action taken or not taken in reliance of the Medical Second Opinion provided under this cover.
10. Utilizing this facility alone will not amount to making a claim under any health insurance policy.
11. No medical Second Opinion can be availed during the break in insurance.

2. b. Specific Exclusions

The Service Provider will not facilitate Medical Second Opinion with the WLMC in the following circumstances where the

1. Insured has not received a diagnosis.
2. Insured has not been evaluated by an attending physician within the last 12 months.
3. Physical Evaluation of the Insured is required.
4. Condition of the Insured is acute or emergency in nature. Medical Second Opinion for the Insured in such cases can be initiated or the process can be continued after the patient is stabilised.

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 Wording 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:

1. **Attending Physician** shall mean the Medical Practitioner/Physician who has locally been attending to the Insured's relevant medical needs and is typically the medical

professional who has been involved in providing the first diagnosis of the relevant medical condition for the Insured Person.

2. **Medical Records** shall mean the written medical files regarding the Insured as developed and maintained by an Attending Physician or other involved medical professionals or facilities. Typically, they include a written summary of the primary diagnosis, an outline of the recommended treatment approach, as well as associated materials such as X-rays, pathology blocks or slides, computer imaging data, lab test results, and additional information reached through clinical evaluation.
3. **Medical Second Opinion (MSO)** shall mean the written opinion of a physician practicing at a World Leading Medical Center provided to the Insured and the Attending Physician regarding his or her diagnosis and course of treatment.
4. **Service Provider** shall mean and include all or any legal entity, who is engaged by the Insurer and named in the policy schedule to provide access to the services that are designed to assist the Insured in their decision making in non-emergency medical conditions by facilitating Medical Second Opinion through its unique relationships with World Leading Medical Centers.
5. **World Leading Medical Center (WLMC)** shall mean a health care facility that is widely known and identified as providing specialized medical care that is recognized within the broad medical community as highly respected in its fields of clinical care.

4. GENERAL CONDITIONS

4.1 Procedure to obtain Medical Second Opinion

In order to obtain the Medical Second opinion,

- Insured has to contact the Service Provider through the Toll-Free number mentioned on the Policy Schedule and provide the
  - Clinical information details,
  - Authorisation to collect medical records from the hospital or attending physician or health care provider and
  - Consent to share the medical records with the WLMC for review and provide Medical Second Opinion by email.
- Based on the Clinical information shared by the Insured, Service Provider will give a choice of 3 World Leading Medical Centers to the Insured, from which the Insured will have an option to choose one WLMC to obtain the Medical Second Opinion.
- WLMC selected by the Insured will review the medical records and write a detailed report with recommendations (Medical Second Opinion).
- Medical Second Opinion received from the WLMC will be sent through secured email to the Insured by the Service Provider with translated version, if required.

  In addition to the Medical Second Opinion, the Service Provider will also arrange

to send a casebook by courier to the Insured Person's address within 10 days from the date of providing medical second opinion by email.

The casebook will consist of the following documents

- The Insured's Medical Second Opinion (Original and translated Version if necessary)
- Medical Records shared by the Insured with the Service Provider
- WLMC and expert physician biographies
- Related journal articles referenced by the expert physician(s)

On the request of the Insured, the Service Provider will organize for a follow up session and a communication bridge between local attending physician of the Insured and WLMC team where questions/ clarifications can be raised or sought by the Insured or the attending physician of the Insured. This service will be paid for by the Service Provider.

4.2 Territorial Limits

The Insured can avail Medical Second Opinion from the World Leading Medical Centers under this policy.

4.3. Service Provider

The Service under this Add-on cover is provided by MediGuide International, an independent Company not affiliated to us. Cholamandalam MS General Insurance Company has entered into an agreement with 'MediGuide International, LLC' and 'MediGuide India Services Private Limited' to provide Medical Second Opinion program through the WLMC empaneled with MediGuide International, LLC. 'MediGuide India' provides local administrative support in India for MediGuide Medical Second Opinion program and necessary assistance to the members who have availed the Add-on cover to obtain the Medical Second Opinion on payment of applicable premium.

4.4 Disclaimer

The Insured hereby understands and agrees that the Services provided under the Medical Second Opinion cover is not independent treatment or diagnosis and should not be solely relied upon as such by the Insured and those Physicians who provide the medical services contemplated by this Policy do not have the benefit of information that would be obtained by examining the Insured in person and observing his or her physical condition. Therefore, the Physician may not be aware of facts or information that would affect his or her opinion of the diagnosis or treatment alternatives or options. The Insured further understands that no warranty or guarantee has been made concerning any particular result or cure of the disease, medical condition, or incapacity.

It is also hereby agreed and recognized by the **Insured**, that the selection of the WLMC is at the sole discretion of the Insured and that the Insurer is not responsible in any way or liable for the availability or quality of any Medical Second Opinion rendered by any World's Leading Medical Centers.

9. 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.

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

Coverage/Plan		Flexi OP Care 1	Flexi OP Care 2	Flexi OP Care 3	Flexi OP Care 4
VALUE ADDED SERVICES	**Discounted Health Checkups**	Not Available	Not Available	Discount on Health Check up's as applicable from the Network Facility on the Digital platform	Discount on Health Check up's as applicable from the Network 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.

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 and AYUSH*.
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.

10. Home Care Treatment – Add on Cover
UIN:CHOHLIA22201V012122

(on payment of additional premium)

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.
5. The list of Health Insurance Products for which the Add-on cover benefit option is

available, is placed at Annexure 2.

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

*Revision/Inclusion in compliance with IRDAI Circular Ref. IRDAI/HLT/CIR/GDL/31/01/2024 dt. 31st January, 2024
Sub: Guidelines on providing AYUSH coverage in Health Insurance policies.

Cholamandalam MS General Insurance Company Limited
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CHOLA HEALTHLINE

*SMS charges as applicable

For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale.Terms and Conditions apply.

Prohibition of rebates 41. (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

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