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Dear Colleagues,

Greetings!

As you know, 21 years ago we embarked on our journey aimed at making insurance simple. Our focus throughout this journey has been a constant effort to bring trust and transparency duly aided by technology.

Now, we bring to you Flexibility; essential for both in business and in life. In a constantly evolving world it acts as an essential tool that empowers and enables us to face the daily business challenges and meet our long-term goals successfully.

Introducing FlexiHealth, our new Health Insurance policy. This will be championed through our new mascot, FlexiMan. He will represent the spirit of our warm, friendly and flexible approach to customers, which also forms the core of FlexiHealth. He will not only come up with interesting trivia to keep you on your toes but will also nudge you in the direction of fun challenges. So gear up to hear more from him!

We have designed key features that are unique only to this policy. Like the flexibility to choose the frequency of premium payments between monthly, quarterly, half yearly and annually along with tenure of the policy, the 100% restoration of unrelated claims, recharge benefit for related claims and reduction of waiting time to 3 years for pre-existing diseases while it is still 4 years in other health insurances. All claims are processed in-house for a smooth customer experience.

FlexiHealth also offers coverage of 539+ day care procedures and cashless hospitalisation across India with our wide network of hospitals.

So let us get together and make our lives as Flexi as possible.

#StayFlexiStayHealthy

With warm regards,

Suryanarayanan V
Managing Director

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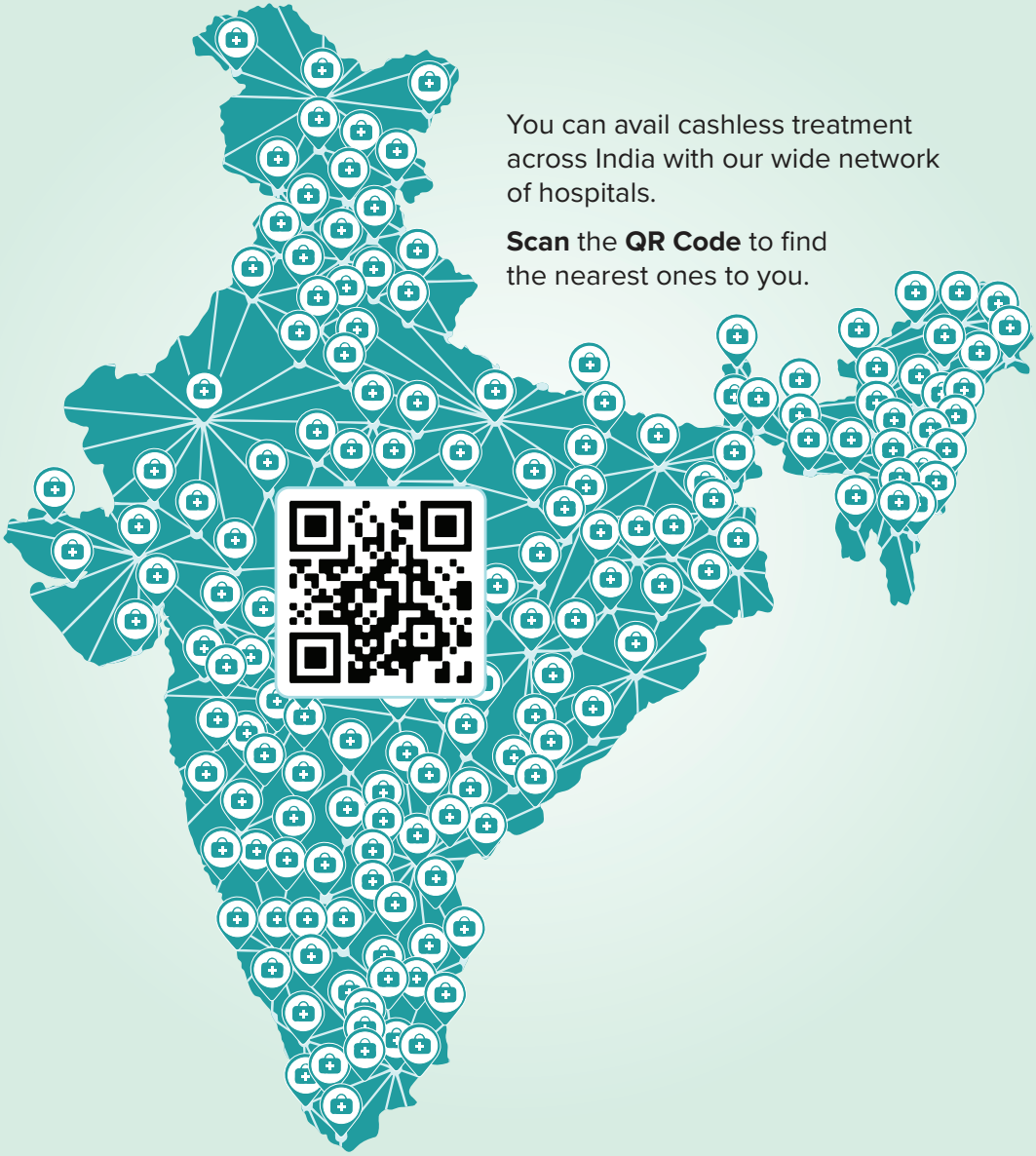

You can avail cashless treatment across India with our wide network of hospitals.

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A] KEY HIGHLIGHTS REGARDING YOUR FLEXIHEALTH POLICY ARE

Policy term 1/2/3 years

Pre Policy Health check up - applicable for those above 50 years of age

Entry age - adult (18 - 65 years) and child (03 months to 26 years)

Individual Cover

- The policy holder can include all family members: Spouse, Children, Dependent Parents, Dependent Parents in-law and Dependant Siblings on individual sum insured basis
- Each person covered will have an independent sum insured limit within the same policy

Family Floater Cover

- Self spouse and children upto a maximum of 6 members can be covered on family floater basis

B] KNOW A LITTLE MORE ABOUT YOUR POLICY

Flexi payment options for the sum insured

Recharge benefit for related claim

Direct claim settlement

Daycare benefit of ₹500/ day towards accompanying person expenses

Waiting period of only 36 months for pre-existing conditions/disease

100% restoration for unrelated claims in the event of exhaustion or insufficient sum insured & cumulativebonus

Age based premium

Life-long renewability

Rates based on the location of the member

Tax exemption under Section 80D of the income tax act

Additional sum insured for claims due to road traffic accident

POLICY WORDINGS

POLICY WORDING

FLEXI HEALTH

UIN: CHOHLIP24145V052425

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 on Individual Sum Insured basis and in case of family coverage 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 Person / Insured / Policyholder / Proposer** in this document refers to **You and all the Insured persons** covered under this policy. The term **Insurer / Us / our / Company** in this document refers to **Cholamandalam MS General Insurance Company Limited.**

1. DEFINITIONS

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in the Policy 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. **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. **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.

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

7. **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

8. *__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.

9. **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.

10. **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.

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

12. **Commencement Date** means the commencement date of this Policy as specified in the Policy Schedule.

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. **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

18. **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.

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

20. **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.

21. **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.

22. **Dependents** means only thefamily members / extended family members listed below, who is related to Primary Insured or proposer.
    - Your legally married Spouse as long as he or she continues to be married to you
    - Your natural or legally adopted Children.
    - Your natural parents or parents that have legally adopted you
    - Parents in Laws as long as your spouse continues to be married to you and
    - Siblings

23. **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.

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

25. **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.

26. **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.

27. **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.

28. **Floater Sum Insured** means the Sum Insured as specified in the Schedule of the policy and is available for any one or all members of the family who have been mentioned as Insured Persons in the Policy Schedule for one or more claims during the period of Insurance.

29. **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.

30. **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

31. **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.

32. **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.

33. **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.

34. **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.

35. **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.

36. **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.

37. **Identificationor ID** card means the card issued to You by us.

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

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

40. **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.

41. **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. For the purpose of this definition, close family members would mean and include the Insured person's Spouse, children (including adopted and step children), Parents, brother, sister, father in law, mother in law, sister in law, brother in law, son in law, daughter in law, uncle, aunt, grandfather, grandmother, grandson, granddaughter, nephew, and niece.

42. **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.

43. **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.

44. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

45. **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.

46. **Network Provider/ Hospital** 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. The list is available with the insurer and subject to amendment from time to time.

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

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

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

50. **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.

51. **Organ Donor** means any person in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules and who donates any of his/her internal organ to the Insured Person subsequent to medical confirmation.

52. **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.

53. **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.

54. **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

55. **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.

56. **Policy period** means the period between the commencement date and earlier of
    a. The Expiry Date specified in the Policy Schedule

b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (7.15) below.

57. **Policy Year** means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.

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. **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.

62. **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.

63. **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.

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

65. **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.

66. **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.

67. **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.

68. **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

69. **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.

2. PERSONS WHO CAN BE INSURED

- This Insurance is available to persons aged between 03 months and 65 years (Completed age) at the commencement date of this policy.
- The Maximum entry age for Children under the policy is 26 Years. Children between 03 months and 18 years can be insured provided either parent is getting insured under this policy.
- The Proposer should be minimum 18 years on the Commencement date of the policy.
- Insured can avail cover for all family members (Self, Spouse, Children, dependent Parents, dependent Parents in Laws and dependent Siblings) on Individual Sum Insured Basis. Each covered person will have an independent Sum Insured limit within the same policy.
- Self, Spouse and Children upto a maximum of 6 members can be covered on Family Floater basis. Single Sum insured floats among the family members covered under the policy.
- Coverage of Self/Proposer is mandatory under Family Floater Cover and is not mandatory under Individual Cover.
- Maximum Renewal age for dependent children is 26 years. On renewal after completion of 26 years, such Insured Person will have the option to migrate to any separate health insurance policy, with continuity benefits.

3. SCHEDULE OF BENEFITS

This policy will cover all the Insured Persons under the policy up to the limits stated in the policy Schedule. The insurance cover is subject to terms, conditions and exclusions of this policy.

Sum Insured (SI) Options		**Rs. 50,000/-, 1/2/3/5/7.5/10/15/20/25 Lakhs**
Basic Covers		
1	In patient Hospitalisation Expenses	Covered
2	Pre-Hospitalisation Expenses	Upto 30 days
3	Post-Hospitalisation Expenses	Upto 60 days

4	Day Care Procedures	Covered
5	AYUSH Coverage	Covered
6	Domiciliary Hospitalisation Cover	Covered
7	Organ Donor Hospitalisation Expenses	Covered
8	Emergency Ambulance Expenses	upto 1% of SI subject to a maximum of Rs.2,000/- per hospitalisation
9	New born Baby Cover	Coverage from Day one
Additional Covers (Over and above the basic Sum Insured)		
1	Sum Insured Restoration for unrelated claims (Applicable for SI Rs.3 lakhs & above)	- Sum Insured Restoration upto 100% for unrelated claims in the event of exhaustion or insufficient Sum Insured & Cumulative Bonus. - This benefit will not be applicable for claims due Road Traffic Accidents.
2	Recharge Benefit for related claims (Applicable for SI Rs.3 lakhs & above)	- Additional Indemnity upto defined limits for related claims. (Hospitalisation for which claims have already been admitted under the policy). - This benefit will not be applicable for claims due to Road Traffic Accidents.
3	Additional Sum Insured for claims due to Road Traffic Accident (RTA) (Applicable for SI Rs.3 lakhs & above)	- Upto 25% of SI subject to a maximum of Rs.3 lakhs once during the policy period. - Restoration and Recharge benefit will not be applicable for claims due to Road Traffic Accidents.
4	Daily Care Benefit	- Daily Benefit of Rs.500/- per day towards accompanying person expenses upto a maximum of 10 days per policy period.
5	Compassionate Travel	- Reimbursement of travel expenses upto a maximum of Rs.5000/- per policy year (per annum in case of multi-year tenure) by air incurred to visit the hospitalized insured by an immediate family member for a life threatening emergency medical condition.
6	Repatriation of Mortal Remains	- Upto Rs.3,000/- subject to an admissible claim under the policy

7	Medical Second Opinion	- Reimbursement of the cost of obtaining Specialist Medical Opinion up to a maximum of Rs.25,000/-
Sublimits		
Room Rent limits		- Upto Rs.2000/- per day for Sum Insured Rs.50,000/-, Rs.1 Lakh & Rs. 2 Lakhs. - No Room limit for Sum Insured above Rs.2 Lakhs
Co-payment		- A Co-payment of 20% 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 - This Co-payment shall not be applicable to any claim under sections- - 4.2.4 (Daily Care Benefit), 4.2.5 (Compassionate Benefit), 4.2.6(Repatriation of Mortal Remains) and 4.2.7(Medical Second Opinion)
Waiting Periods		
30 Days Waiting Period		Applicable
2 Yr Waiting Period		Applicable
Pre-existing Disease		36 Months
Renewal Benefits		
Cumulative Bonus		10% - 50%
Reduction in Cumulative Bonus		10%
Health Checkup		Once in two claim free years upto defined limits

In 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.

4. POLICY COVERAGE

Upon the happening of the events under sections 4.1 and 4.2 below during the policy period, we will indemnify the Insured 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 7 of this policy.

4.1. BASIC COVERS		
	Benefits	**Coverage & Specific Conditions**
4.1.1	**In Patient Hospitalisation Expenses**	This Policy will indemnify for medically necessary inpatient treatment expenses, under different heads mentioned below, incurred during the policy period towards Hospitalisation for the disease, illness (including Mental illness), medical condition or injury contracted or sustained by the insured person during the Policy Period as stated in the policy Schedule subject to terms, conditions and exclusions mentioned in the Policy. a. Room, Boarding charges as provided by the Hospital/Nursing Home in normal rooms or in ICU b. Nursing Expenses incurred during In-Patient Hospitalisation c. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees d. Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, and diagnostic tests) e. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, and Medicines & Drugs, Diagnostic Materials and Cost of Pacemaker, prosthetic and other devices implanted internally during a surgical procedure. For Sum Insured Rs.50,000/-, Rs. 1 Lakh and 2 Lakhs, the maximum room rent allowed is Rs.2000/-per day.
4.1.2	**Pre Hospitalisation Expenses**	This Policy will pay for medical expenses incurred upto the number of days as mentioned in the Schedule of benefits prior to the date of Hospitalisation provided that a. The expenses were incurred after the first 30 day waiting period as mentioned in Waiting Period no 5.iii b. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and c. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by Us Payment under this benefit will reduce the Sum Insured.

4.1.3	**Post Hospitalisation Expenses**	This Policy will pay for medical expenses incurred up to the number of days as mentioned in the Schedule of benefits from the date of discharge from the hospital 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 Us Payment under this benefit will reduce the Sum Insured
4.1.4	**Day Care Procedures**	This Policy will pay for Medical Expenses incurred as a Day Care Procedure/Treatment per Annexure 1 that requires less than 24 hours of Hospitalisation, up to Sum Insured stated 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. Payment under this benefit will reduce the Sum Insured
4.1.5	***AYUSH Coverage**	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 up to 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 Payment under this benefit will reduce the Sum Insured
4.1.6	**Domiciliary Hospitalisation**	This policy will reimburse the Medical Expenses incurred by an Insured Person for medical treatment taken at his/her home which would otherwise have required Hospitalisation provided: a) On the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or b) a Hospital bed was unavailable, and provided that: I. The condition for which the medical treatment is required continues for at least 3 days, in which case the Policy pays reasonable cost of necessary medical treatment for the entire period II. Pre-hospitalisation and Post hospitalisation expenses will be covered under this benefit in accordance with Section 4.1.2 and 4.1.3 respectively.

		III. No payment will be made under this benefit if the condition for which the Insured Person requires medical treatment towards following ailments 1. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza 2. Arthritis, Gout and Rheumatism 3. Chronic Nephritis and Nephritic Syndrome 4. Diarrhoea and all types of Dysenteries including Gastroenteritis 5. Diabetes Mellitus and Insupidus 6. Epilepsy 7. Hypertension 8. Pyrexia of unknown Origin Cashless facility will not be available for such a claim. Payment under this benefit will reduce the Sum Insured
4.1.7	**Organ Donor Hospitalisation Expenses**	This policy 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 Payment under this benefit will reduce the Sum Insured
4.1.8	**Emergency Ambulance Expenses**	This policy 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: a. The ambulance service is offered by a healthcare or an ambulance service provider b. We have accepted the inpatient hospitalisation claim under section 4.1.1 above Payment under this benefit will reduce the Sum Insured
4.1.9	**New Born Baby Cover**	This policy will pay for the Inpatient hospitalisation medical expenses incurred for the New Born Baby from Day one till policy expiry date mentioned in the policy schedule subject to a limit of 10% of Sum Insured subject to a maximum of Rs.50,000/- whichever is less within Mother's Sum Insured provided that 1. The mother is covered under the policy for a period of 12 months continuously without break. 2. Intimation about the birth of the New Born Baby is given to us and the baby is included and endorsed under the policy for the cover to commence. 3. Routine Vaccinations for the baby are not admissible under this cover.

		4. 30 days waiting period shall not apply for the New Born Baby cover 5. All other terms, conditions and exclusions shall apply for the New Born Baby cover. In case of Family Floater, the floater Sum Insured will be considered upto the limits stated above for New Born Baby cover. Payment under this benefit will reduce the Sum Insured

The total amount payable under the policy per year for all sections under 4.1 as above put together shall not exceed the sum insured for you shown in the policy schedule.

4.2 ADDITIONAL COVERS (Over and Above the Basic Sum Insured)		
Benefits		**Coverage & Specific Conditions**
4.2.1	**Sum Insured Restoration for unrelated claims** (applicable for Sum Insured 3 Lakhs and above)	This policy will provide for a 100% restoration of Sum Insured during that policy year, provided that: a. The Sum Insured and earned Cumulative Bonus is insufficient or exhausted as a result of previous claims during the policy year. b. The Restored Sum Insured shall not be available for claims towards an Illness/disease/Injury (including its complications) for which a claim has been paid during the policy year for the same Insured Person. c. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under basic **Inpatient Hospitalisation Expenses cover** and shall not apply to the first claim in the Policy Year. d. No Restoration of the Sum Insured will be provided for coverage under basic covers vide Section 4.1.2 to 4.1.9 and additional covers vide section 4.2.2 to 4.2.7 e. Sum Insured Restoration is applicable only for the current policy year and any unused Sum Insured cannot be carried forward to the next policy year. This policy does not cease on payment of claim under this benefit f. Such restoration of Sum Insured will be available only once during a Policy Year to each insured in case of an individual Sum Insured. If the Policy is issued on a floater basis, the Restored Sum Insured will be available on a floater basis All Claims under this benefit can be made as per the process defined under Section 6.26.a & 6.26.b. Sum Insured Restoration benefit will not be applicable for any claims arising out of Road Traffic Accident

<table>
<tr>
<td>4.2.2</td>
<td>Recharge Benefit for related claims
(applicable for Sum Insured 3 Lakhs and above)</td>
<td>In the event of exhaustion of Sum Insured and Cumulative Bonus during the policy period, recharge benefit up to the following limits will be provided once during the policy year for reimbursement of medical expenses under basic Inpatient Hospitalisation Expenses for treatment of same disease, illness, medical condition or injury for which claim was paid under the policy during the policy period.
No Recharge benefit will be provided for fresh unrelated claims and for basic covers vide Section 4.1.2 to 4.1.9 and additional covers vide section 4.2.3 to 4.2.7.
This benefit will be triggered on exhaustion of the Sum Insured and Cumulative Bonus under the policy
Recharge benefit will not be applicable for any claims arising out of Road Traffic Accident
The unutilized Recharge amount cannot be carried forward
<table>
<tr><th>Sum Insured (in Rs.)</th><th>Recharge Benefit Limit</th></tr>
<tr><td>3 Lakhs</td><td>Rs.75,000/-</td></tr>
<tr><td>5 Lakhs</td><td>Rs.1,25,000/-</td></tr>
<tr><td>7.5/10/15Lakhs</td><td>Rs.1,50,000/-</td></tr>
<tr><td>20/25 Lakhs</td><td>Rs.2,00,000/-</td></tr>
</table>
</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Additional Sum Insured for claims due to Road Traffic Accident (RTA)
(applicable for Sum Insured 3 Lakhs and above)</td>
<td>In the event of Hospitalisation of the insured due to an Accident, the basic Sum Insured shall be increased by 25% subject to a maximum of Rs.3 lakhs provided that:
• The additional Sum Insured will be available on exhaustion of the Basic Sum Insured and Cumulative Bonus under the policy
• This cover will be available only once during the policy year and can be utilized only for that particular hospitalisation due to RTA
• Sum Insured Restoration and Recharge Benefit will not be applicable for this benefit
The unutilized amount under this benefit cannot be carried forward</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Daily Care Benefit</td>
<td>This policy will pay daily cash benefit as mentioned in the Schedule of benefits towards accompanying person expenses, for each and every completed 24 hours of hospitalisation up to a maximum of 10 days per policy year
For a claim to be admissible under this benefit, we should have accepted an inpatient Hospitalisation claim under Section 4.1.1 above
Claim payment under this cover does not form part of the Sum Insured but will impact Cumulative Bonus</td>
</tr>
</table>

4.2.5	**Compassionate Travel**	In the event of the hospitalisation of the insured for a Life-threatening Medical Emergency at a place away from his usual place of residence as recorded in the policy, the policy will reimburse the transportation expenses incurred for air travel up to the maximum limit mentioned in the Schedule of Benefits for one of the immediate family member (other than the travel companion) to travel to the hospital, provided the claim for Hospitalisation is admissible under the policy The benefit amount mentioned in the Schedule of Benefits will be maximum limit applicable per policy year (per annum in case of multi-year tenure) In relation to individual policy it is our maximum liability for each Insured Person per policy year (i.e., per annum for multi-year tenure) and in relation to a Family Floater it is our maximum liability for the all the Insured Persons covered under the policy per policy year (i.e., per annum for multi year tenure) For the purpose of this cover Life-Threatening Medical Emergency means a medical condition potentially fatal which could result in death of the life of the Insured Immediate family member shall mean and include the Insured Person's Spouse, children (including adopted and step children) and parents The scope of this cover is within the boundaries of India This benefit will be available only on reimbursement basis Claim payment under this cover does not form part of the Sum Insured but will impact Cumulative Bonus
4.2.6	**Repatriation of Mortal Remains**	This policy will reimburse the actual expenses subject to the maximum limit mentioned in the Schedule of Benefits incurred for transportation of mortal remains of the Insured Person from the hospital to the residence and/or cremation and/or burial ground subject to an admissible claim under basic Inpatient Hospitalisation cover This benefit will be available only on reimbursement basis Claim payment under this cover does not form part of the Sum Insured but will impact Cumulative Bonus

4.2.7	**Medical Second Opinion**	This policy will reimburse the cost of obtaining Medical Second Opinion from a Specialist Medical Practitioner for illness (including Mental Illness) or injury up to a maximum limit as mentioned in the Schedule of Benefits subject to an admissible claim under basic Inpatient Hospitalisation cover. 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 Claim payment under this cover does not form part of the Sum Insured but will impact Cumulative Bonus
4.2.8	**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 20% shall be applied on each and every admissible claim This Co-payment shall not be applicable to any claim under sections- 4.2.4 (Daily Care Benefit), 4.2.5 (Compassionate Benefit), 4.2.6(Repatriation of Mortal Remains) and 4.2.7(Medical Second Opinion)

4.3 RENEWAL BENEFITS		
4.3.1	**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 the 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 50% 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 be 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

<table>
<tr><td>4.3.2</td><td>Reduction in Cumulative Bonus</td><td>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 Benefits
Such a reduction of cumulative bonus will not reduce the Sum Insured under the policy
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</td></tr>
<tr><td>4.3.3</td><td>Health Check-up</td><td>All Insured Persons under this policy will be eligible for a Health Check-up up to the limits defined below after two continuous claim free policy years
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
iii. The limits defined below will be the maximum amount payable for any one or all the Insured Persons towards the Health Checkup
The medical Check-up can be availed on Cashless basis in the Hospital/Diagnostic Centres empanelled with the Insurer or on Reimbursement basis at the option of the Insured
On reimbursement basis, the Insured should submit the copy of the reports and original payment receipt within 30 days from the last date of undergoing the Health Check-Up
Payment under this benefit does not form part of the Sum Insured and will not impact the Bonus
Note: Payment of expenses towards cost of health Check-up will not prejudice the company’s right to deal with a claim in case of non disclosure of material fact and/or Pre-Existing Diseases in terms of the policy
<table>
<tr><th>Sum Insured (in Rs.)</th><th>Benefit Limit</th></tr>
<tr><td>Rs. 1 / 2 Lakhs</td><td>Rs.500/-</td></tr>
<tr><td>Rs.3 Lakhs</td><td>Rs.750/-</td></tr>
<tr><td>Rs. 5 Lakhs</td><td>Rs.1000/-</td></tr>
<tr><td>Rs.7.5/10 Lakhs</td><td>Rs.2500/-</td></tr>
<tr><td>Rs.15/20 Lakhs</td><td>Rs.3000/-</td></tr>
<tr><td>Rs.25 Lakhs</td><td>Rs.3500/-</td></tr>
</table>
</td></tr>
</table>

5. WAITING PERIODS

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 Anomaly (except for coverage under 4.1.9 New born baby cover)
   b. Treatment of diseases on ears/tonsils/adenoids/paranasal sinuses/Deviated Nasal Septum
   c. Cataract
   d. Benign Prostatic Hypertrophy
   e. Myomectomy, Hysterectomy unless because of malignancy
   f. All types of Hernia
   g. Hydrocele
   h. Varicose Veins and Varicose Ulcers
   i. Rheumatism and arthritis of any kind
   j. Stones in the Urinary and Biliary Systems

k. Any type of benign Cyst/Nodules/Polyps/Tumours/Breast Lumps unless malignant

l. Intervertebral Disc Prolapse, and Degenerative Disc/vertebral Disorders

m. Dilatation and curettage (D&C)

n. Joint replacement Surgery unless because of accident

o. ENT disorders & Surgery

p. Spondylosis/Spondylitis and other Degenerative Disc Disorders

q. Ligament, Tendon and Meniscal tear

r. Genetic Disorders

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.

6. GENERAL EXCLUSIONS

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

1. **Investigation & Evaluation-Code-Excl04:**
   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-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.
3. **Obesity/Weight Control: Code-Excl06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor
   2) The surgery/Procedure conducted should be supported by clinical protocols
   3) The member has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      a) Greater than or equal to 40 or

b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe sleep Apnea
   iv. Uncontrolled Type2 Diabetes

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-Excl07**
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-Excl08**
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-Excl09**
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 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. **Excl12**
10. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl13**
11. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. **Code-Excl14**
12. **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **Code-Excl15**
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-Excl16**
14. **Sterility and Infertility: Code-Excl17:** Expenses related to Sterility and infertility.

This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. **Maternity: Code-Excl18:**

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

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

16. War or any act of war, invasion, acts of foreign enemies, hostilities whether war 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.
24. Any external congenital diseases, defects or anomalies.
25. Expenses incurred for any dental treatment or surgery of a corrective, cosmetic or aesthetic nature unless it requires hospitalisation and is carried out under general anaesthesia and is necessitated by Illness or Accidental Bodily Injury.
26. Any expenses incurred 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 like spouse, daughter, son, father, mother, father in law, mother in law & siblings.
29. Treament other than Allopathy and AYUSH*.
30. Claims arising out of the treatment/operation undertaken to cure impotence or to improve potency.

31. Non-medical Expenses incurred during Hospitalisation. The list of such Non medical Expenses is placed at Annexure2.

7. GENERAL CONDITIONS

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.

2. 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).

3. 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.

4. 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.

5. 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. 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.

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 Renewal Benefit 3.3 of the Policy.

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 at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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).

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.

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

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.

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.

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.

14. 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.

15. 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

   Minimum premium of Rs.250/-per policy will be retained by us towards administrative charges.

   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.

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.

17. Cost of Pre Policy Health Check-up

- Pre-acceptance Medical 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.

18. Premium Payment

a. Premium Payment Modes available under the policy:

The proposer shall have the following options to pay the premium:

1. Single Premium payment prior to commencement of cover

or

2. Payment of premium on Monthly, Quarterly, Half-Yearly and Annual modes

This option shall be made at the time of proposing for insurance and the opted mode will be shown on the policy schedule.

Mode of Premium payment can be changed only at the time of renewal.

b. Specific Conditions applicable to other than single premium payment mode:

1. This mode is applicable for One, Two and Three year policy Terms.
2. In the event of proposer opting for other than single payment mode, the premium payable for the first 3 Months from the date of commencement of cover has to be paid upfront by way of Cheque/Direct Debit mode in favour of "Cholamandalam MS General
3. The premium should be paid on or before the due date as opted and specified in the Policy Schedule and not later than the grace period mentioned below. We condone this delay and continue the policy with continuity benefits:

Premium Payment mode	Grace Period from due date for premium payment
Monthly	15 days
Quarterly	30 days
Half-Yearly	30 days
Annual	30 days

4. The policy will be in force during the grace period and any claim arising during the grace period will be payable subject to policy terms and conditions.
5. In the event of two successive premium payment defaults, the policy will terminate effective from the original payment due date. The premium paid hereon shall be forfeited to the Company. Thereafter the insured can only avail a fresh policy with all applicable waiting periods.
6. In case the premium is received after the grace period expiry and before subsequent premium payment due date, the policy stands revived with continuity benefits.
7. Any premium payment received after the Grace Period and before subsequent premium due date will be accepted by Us subject to an additional amount of Rs.500/- towards administrative charges.
8. No refund/paid-up will be payable on cancellation of the policy by the Insured during the premium default period.
9. Due date for premium payments and payment mode chosen will be as shown in the Policy Schedule.
10. The following conditions will apply in the event of claims under the policy (notwithstanding any terms contrary elsewhere in the policy):
    a. In case of any hospitalisation claim, an amount equivalent to the balance of the premium payable in the policy year (balance premium for the policy year in case of a long-term policy) would be recoverable from the admissible claim amount payable in respect of the Insured Person in case of Individual Policy or in respect of the family in case of Family floater policy.
    b. If the claim amount is less than the balance premium payable, then no claims will be payable till the applicable premium is recovered.

19. Underwriting Loading

Risk loading may be applied on premium payable (excluding taxes and cess) based on the details of the Insured Persons, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and results of the Pre-Policy medical check-up. The maximum risk loading for an individual shall not exceed 100%.

These loadings are applicable from commencement date of policy including subsequent renewal(s). A specific exclusion 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.

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

20. 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.

21. Transfer

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

22. 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.

23. 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.

24. 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.

25. Assignment

The policy can be assigned subject to applicable laws.

26. 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, then it is a condition precedent to our liability that You shall immediately :

a. Give us intimation 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

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

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

c. Procedure for submission of Reimbursement Claims

1. Upon Hospitalization, the insured Person or his/her dependents shall provide us with fully particularized 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. Insured hereby 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 recognized 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-authorized 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/Home Care Treatment	- 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.
Compassionate Travel	• Documents as stated above and • Original ticket issued by common carrier for travelling from the place of residence to the place where the insured is hospitalised.

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**

Email ID: 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

Upon the Cancellation or non-renewal of this Policy, all ID cards shall immediately be returned to us at the Insured person's expense. The Proposer and all insured Persons agree to hold and keep us harmless against any and all costs, expenses, liabilities and claims arising in respect of the actual or alleged use or misuse of such ID Cards prior to their return.

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

27. 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.

28. 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.

29. 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.

30. 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, the Sum Insured revision is subject to written application and our acceptance. 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 days, 2 years and 3 years waiting periods as per waiting periods 5.i, 5.ii and 5.iii above

31. Automatic Termination

This policy shall terminate immediately on the earlier of the following events irrespective of the expiry date mentioned in the policy schedule

Upon the demise of the covered person, in which case the Company will refund premium calculated on pro-rata basis for the unexpired period subject there being no claim under the policy.

Upon exhaustion of the Sum Insured. However this will not affect the renewal for the subsequent period.

32. 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.

8. GRIEVANCES REDRESSAL MECHANISM

Mechanism for Grievance Redressal:-

In case of any grievance the insured person may contact the company through

Website : www.cholainsurance.com

Toll free : 1800 208 9100

E-Mail : customercare@cholams.murugappa.com

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

Benefit Illustration in respect of policies offered on individual and family floater basis

FLEXI HEALTH, Policy Period - ONE Year, Tier -1, Single Premium Payment Mode										
Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (sum insured is available for each member of the family)				Coverage opted on family floater basis with overall sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discounts if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all family members	Floater discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
18	5,840	5 Lakhs	5,840	NIL	5,840	5 Lakhs	27,430	NIL	27,430	5 Lakhs
23	6,524	5 Lakhs	6,524	NIL	6,524	5 Lakhs				
48	10,899	5 Lakhs	10,899	NIL	10,899	5 Lakhs				
54	15,410	5 Lakhs	15,410	NIL	15,410	5 Lakhs				
Total premium for all members of the family is Rs. 38,673/-, when each member is covered separately.			Total premium for all members of the family is Rs. 38,673/-, when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs. 27,430/-			
Sum Insured available for each individual is Rs.5 Lakhs			Sum Insured available for each family member is Rs.5 Lakhs				Sum Insured of Rs.5 Lakhs is available for the entire family.			
Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable.										

FLEXI HEALTH, Policy Period - ONE Year, Tier -1, Single Premium Payment Mode										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (sum insured is available for each member of the family)**				**Coverage opted on family floater basis with overall sum insured (Only one sum insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discounts if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or consolidated premium for all family members**	**Floater discount if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
31	7,766	5 Lakhs	7,766	NIL	7,766	5 Lakhs	**Children not covered above 26 years of age**			
60	21,682	5 Lakhs	21,682	NIL	21,682	5 Lakhs	48,842	NIL	48,842	5 Lakhs
65	28,730	5 Lakhs	28,730	NIL	28,730	5 Lakhs				
Total premium for all members of the family is Rs. 58,178/-, when each member is covered separately.			Total premium for all members of the family is Rs. 58,178/-, when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs. 48,842/-			
Sum Insured available for each individual is Rs.5 Lakhs			Sum Insured available for each family member is Rs.5 Lakhs				Sum Insured of Rs.5 Lakhs is available for the entire family.			
Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable.										

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 DAY CARE PROCEDURES

Kindly note that the procedures mentioned below are only illustrative and not exhaustive. Any other Medical treatment or surgical procedure which is undertaken under general or local anaesthesia and which require admission in a Hospital/Day Care Centre, where hospital stay is less than 24 hours due to technological advancement only, shall also be considered as Day care procedures for the purpose of indemnity under this policy.

Treatment normally taken on an OPD basis will not be considered under day care procedure/surgery

Sl. No.	DENTAL AND ENT RELATED
1	SPLINTING OF AVULSED TEETH
2	SUTURING LACERATED LIP
3	SUTURING ORAL MUCOSA
4	ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
5	FNAC
6	SMEAR FROM ORAL CAVITY
7	MYRINGOGOMY WITH GROMMET INSERTION
8	TYMPANOPLASTY (CLOUSE OF AN EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSCILES)
9	REMOVAL OF A TYMPANIC DRAIN
10	KERATOSIS REMOVAL UNDER GA
11	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
12	REMOVAL OF KERATOSIS OBTURBANS
13	STAEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
14	REVISION OF A STAPEDECTOMY
15	OTHER OPERATIONS ON THE AUDITORY OSSICLES
16	MYRINGOPLASTY (POST-AURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE-I TYMPANOPLASTY)
17	FENESTRATIO NON THE INNER EAR
18	REVISION OF A FENESTRATION OF THE INNER EAR
19	PALATOPLASTY
20	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
21	TONSILLECTOMY WITHOUT ADENOIDECTOMY
22	TONSILLECTOMY WITH ADENOIDECTOMY
23	EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
24	REVISION OF A TYMPANOPLASTY

25	OTHER MICROSURGICAL OPERATION ON THE MIDDLE EAR

26	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
27	MASTOIDECTOMY
28	RECONSTRUCTION OF THE MIDDLE EAR
29	OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
30	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
31	OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
32	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
33	OTHER OPERATIONS ON THE NOSE
34	NASAL SINUS ASPIRATION
35	FOREIGN BODY REMOVAL FROM NOSE
36	OTHER OPERATION ON THE TONSILS AND ADENOIDS
37	ADENOIDECTOMY
38	LABYRINTHECTOMY FOR SEVERE VERTIGO
39	STAPEDECTOMY UNDER GA
40	STAPEDECTOMY UNDER LA
41	TYMPANOPLASTY (TYPE IV)
42	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
43	TURBINECTOMY
44	ENDOSCOPIC STAPEDECTOMY
45	INCISION AND DRAINAGE OF PERICHONDRITIS
46	SEPTOPLASTY
47	VESTIBULAR NERVE SECTION
48	THYROPLASTY TYPE I
49	PSEUDOCYST OF THE PINNA EXCISION
50	INCISION AND DRAINAGE-HAEMATOMA AURICLE
51	TYMPANOPLASTY (TYPE II)
52	REDUCTION OF FRACTURE OF NASAL BONE
53	THYROPLASTY TYPE II
54	TRACHEOSTOMY
55	EXCISION OF ANGIOMA SEPTUM
56	TURBINOPLASTY
57	INCISION & DRAINAGE OF RETROPHARYNGEAL ABSCESS
58	UVULOPALATOPHARYNGOPLASTY

59	ADENOIDECTOMY WITH GROMMET INSERTION
60	ADENOIDECTOMY WITHOUT GROMMET INSERTION
61	VOCAL CORD LATERALISATION PROCEDURE
62	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
63	TRACHEOPLASTY
GASTROENTEROLOGY RELATED	
64	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/DUODENOSTOMY/ GASTROSTOMY/EXPLORATION COOMON BILE DUCT
65	ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
66	PANCREATIC PSEUDOCYST EUS&DRAINAGE
67	RF ABLATION FOR BARRET'S OESOPHAGUS
68	ERCP AND PAPILLOTOMY
69	ESOPHAGOSCOPE AND SCLEROSANT INJECTION
70	EUS+SUBMUCOSAL RESECTION
71	CONSTRUCTION OF GASTROSTOMY TUBE
72	EUS+ASPIRATION RESECTION
73	SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
74	COLONOSCOPY LESION REMOVAL
75	ERCP
76	COLONOSCOPY STENTING OF STRICTURE
77	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
78	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
79	ERCP AND CHOLEDOCHOSCOPY
80	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
81	ERCP AND SPHINCTEROTOMY
82	ESOPHAGEAL STENT PLACEMENT
83	ERCP+PLACEMENT OF BILIARY STENTS
84	SIGMOIDOSCOPY W/STENT
85	EUS+COELIAC NODE BIOPSY
86	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS
87	BLEEDING ULCERS
GENERAL SURGERY RELATED	
88	INCISION OF A PILONIDAL SINUS/ABSCESS
89	FISSURE IN ANOSHPHINCTEROTOMY

90	SURGICAL TREATENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
91	ORCHIDOPEXY
92	ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
93	SURGICAL TREATMENT OF ANAL FISTULAS
94	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
95	APIDIDYMECTOMY
96	INCISION OF THE BREAST ABSCESS
97	OPERATIONS ON THE NIPPLE
98	EXCISION OF SINGLE BREAST LUMP
99	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
100	SURGICAL TREATMENT OF HEMORRHOIDS
101	OTHER OPERATIONS ON THE ANUS
102	ULTRASOUND GUIDED ASPIRATIONS
103	SCLEROTHERAPY, ETC
104	LAPAROTOMY FOR GRADING LYMPHOMA WITH SPLENECTOMY/LIVER/LYMPH NODE BIOPSY
105	THERAPEUTIC LAPAROSCOPY WITH LASER
106	APPENDICECTOMY WITH/WITHOUT DRAINAGE
107	INFECTED KELOID EXCISION
108	AXILLARY LYMPHADENECTOMY
109	WOUND DEBRIDEMENT AND COVER
110	ABSCESS-DECOMPRESSION
111	CERVICAL LYMPHADENECTOMY
112	INFECTED SEBACEOUS CYST
113	INGUINAL LYMPHADENECTOMY
114	INCISION AND DRAINAGE OF ABSCESS
115	SUTURING OF LACERATIONS
116	SCALP SUTURING
117	INFECTED LIPOMA EXCISION
118	MAXIMAL ANAL DILATION
119	PILES
120	INJECTION SCLEROTHERAPY
121	PILES BANDING
122	LIVER ABSCESS-CATHETER DRAINAGE

123	FISSURE IN ANO-FISSURECTOMY
124	FIBROADENOMA BREAST EXCISION
125	OESOPHAGEAL VARICES SCLEROTHERAPY
126	ERCP-PANCREATIC DUCT STONE REMOVAL
127	PERIANAL ABSCESS I&D
128	PERIANAL HEMATOMA EVACUATION
129	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
130	BREAST ABSCESS I&D
131	FEEDING GASTROSTOMY
132	OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
133	ERCP-BILEDUCT STONE REMOVAL
134	ILEOSTOMY CLOSURE
135	COLONOSCOPY
136	POLYPECTOMY COLON
137	SPLENIC ABSCESSES LAPROSCOPIC DRAINAGE
138	UGISCOPY AND POLYPECTOMY STOMACH
139	RIGID OESOPHAGAOSCOPY FOR REMOVAL
140	FEEDING JEJUNOSTOMY
141	COLOSTOMY
142	ILEOSTOMY
143	COLOSTOMY CLOSURE
144	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
145	PNEUMATIC REDUCTION OF INTUSSUSCEPTION
146	VARICOSE VEINS LEGS-INJECTION SCELROTHERAPY
147	RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
148	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
149	ZADEK'S NAIL BED EXCISION
150	SUBCUTANEOUS MASTECTOMY
151	EXCISIOIN OF RANULA UNDER GA
152	RIGID OESOPHAGAOSCOPY FOR DILATION OF BENIGN STRICTURES
153	EVERSION OF SAC
154	UNILATERAL
155	ILATERAL
156	LORD'S PLICATION
157	JABOULAY'S PROCEDURE

158	SCROTOPLATY
159	CIRCUMCISION FOR TRAUMA
160	MEATOPLASTY
161	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
162	PSOAS ABSCESS INCISION AND DRAINAGE
163	THRYROID ABSCES INCISION AND DRAINAGE
164	TIPS PROCEDURE FOR PORTAL HYPERTENSION
165	ESOPHAGEAL GROWTH STENT
166	PAIR PROCEDURE OF HYDATID CYST LIVER
167	TRU CUT LIVER BIOPSY
168	PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
169	EXCISION OF CERVICAL RIB
170	LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
171	MICRODOCHECTOMY BREAST
172	SURGERY FOR FRACTURE PENIS
173	SENTINEL NODE BIOPSY
174	PARASTOMAL HERNIA
175	REVISION COLOSTIMY
176	PROLAPSED COLOSTOMY-CORRECTION
177	TESTICULAR BIOPSY
178	LAPAROSCOPIC CARIOMYOMOTMY (HELLERS)
179	SENTINEL NODE BIOPSY MALIGNANT MELANOMA
180	LAPAROSCOPIC PYLOROMYOTOMY (RAMSTEDT)
181	INSERT NON-TUNNEL CV CATH
182	INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
183	REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
184	INSERTION CATHETER INTRA ANTERIOR
185	INSERTION OF PORTACATH
GYNECOLOGY RELATED	
186	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
187	INCISION OF THE OVARY
188	INSUFFLATIONS OF THE FALLOPIAN TUBE
189	OTHER OPERATIONS ON THE FALLOPIAN TUBE
190	DILATION OF THE CERVICAL CANAL
191	CONSIATION OF TE UTERINE CERVIX

192	THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/DIATHERMY/ CRYOSURGERY
193	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
194	OTHER OPERATIONS ON THE UTERINE CERVIX
195	INCISION OF THE UTERUS (HYSTERECTOMY)
196	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
197	INCISION OF VAGINA
198	INCISION OF VULVA
199	CULDOTOMY
200	SALPINGO-OOPOHORECTOMY VIA LAPAROTOMY
201	ENDOSCOPIC POLYPECTOMY
202	HYSTEROSCOPIC REMOVAL MYOMA
203	D&C
204	HYSTEROSCOPIC RESECTION OF SEPTUM
205	THERMAL CAUTERISATION OF CERVIX
206	MIRENA INSERTION
207	HYSTEROSCOPIC ADHESIOLYSIS
208	LEEP
209	CRYOCAUTERISAITON OF CERVIX
210	POLYPECTOMY ENDOMETRIUM
211	HYSTEROSCOPIC RESECTION OF FIBROID
212	LLETZ
213	CONIZATION
214	POLYPECTOMY CERVIX
215	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
216	VULVAL WART EXCISION
217	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
218	UTERINE ARTERY EMBOLIZATION
219	LAPAROSCOPIC CYSTECOMY
220	HYMENECTOMY (IMPERFORATE HYMEN)
221	ENDOMETRIAL ABLATION
222	VAGINAL WALL CYST EXCISION
223	VULVAL CYST EXCISION
224	LAPAROSCOPIC PARATUBAL CYST EXCISION

225	REPAIR OF VAGINA (VAGINAL ATRESIA)
226	HYSTEROSCOPY, REMOVAL OF MYOMA
227	TURBT
228	URETEROCELE REPAIR-CONGENITAL INTERNAL
229	VAGINAL MESH FOR POP
230	LAPROSCOPIC MYOMECTOMY
231	SURGERY FOR SUI
232	REPAIR RECTO-VAGINAL FISTULA
233	PELVIC FLOOR REPAIR (EXCLUDING FISTULA REPAIR)
234	URS+LL
235	LAPAROSCOPIC OOPHORECTOMY
236	NORMAL VAGINAL DELIVERY AND VARIANTS
NEUROLOGY RELATED	
237	FACIAL, NERVE PHYSIOTHERAPY
238	NERVE BIOPSY
239	MUSCLE BIOPSY
240	EPIDURAL STEROID INJECTION
241	GLYCEROL RHIZOTOMY
242	SPINAL CORD STIMULATION
243	MOTOR CORTEX STIMULATION
244	STEREOTACTIC RADIOSURGERY
245	PERCUTANEOUS CORDOTOMY
246	INTRATHECAL BACLOFEN THERAPY
247	ENTRAPMENT NEUROPATHY RELEASE
248	DIAGNOSTIC CEREBRAL ANGIOGRAPHY
249	VP SHUNT
250	VENTRICULOATRIAL SHUNT
ONCOLOGY RELATED	
251	RADIOTHERAPY FOR CANCER
252	CANCER CHEMOTHERAPY
253	IV PUSH CHEMOTHERAPY
254	HBI-HEMIBODY RADIOTHERAPY
255	INFUSIONAL TARGETED THERAPY
256	SRT-STEREOTACTIC ARC THERAPY
257	SC ADMINISTRATION OF GROWTH FACTORS

258	CONTINUOUS INFUSIONAL CHEMOTHERAPY
259	INFUSIONAL CHEMOTHERAPHY
260	CCRT-CONCURRENT CHEMO+RT
261	2D RADIOTHERAPY
262	3D CONFORMAL RADIOTHERAPY
263	IGRT-IMAGE GUIDED RADIOTHERAPY
264	IMRT-STEP & SHOOT
265	INFUSIONAL BISPHOSPHONATES
266	IMRT-DMLC
267	ROTATIONAL ARC THERAPY
268	TELE GAMMA THERAPY
269	FSRT-FRACTIONATED SRT
270	VIMAT-VOLUMETRIC MODULATED ARC THERAPY
271	SBRT-STEREOTACTIC BODY RADIOTHERAPY
272	X-KNIFE SRS
273	GAMMA KNIFE SRS
274	TBI-TOTAL BODY RADIOTHERAPY
275	INTRALUMINAL BRACHYTHERAPY
276	ELECTRON THERAPY
277	TSET-TOTAL ELECTRON SKIN THERAPY
278	EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
279	TELECOBALT THERAPY
280	TELECESIUM THERAPY
281	EXTERNAL MOULD BRACHYTHERAPY
282	INTERSTITIAL BRACHYTHERAPY
283	INTRACAVITY BRACHYTHERAPY
284	3D BRACHYTHERAPY IMPLANT
285	IMPLANT BRACHYTHERAPY
286	INTRAVESICAL BRACHYTHERAPY
287	ADJUVANT RADIOTHERAPY
288	AFTERLOADING CATHETER BRACHYTHERAPY
289	CONDITIONING RADIOTHERAPY FOR BMT
290	EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
291	RADICAL CHEMOTHERAPY
292	NEOADJUVANT RADIOTHERAPY

293	LDR BRACHYTHERAPY
294	PALLIATIVE RADIOTHERAPY
295	RADICAL RADIOTHERAPY
296	PALLIATIVE CHEMOTHERAPY
297	TEMPLATE BRACHYTHERAPY
298	NEOADJUVANT CHEMOTHERAPY
299	ADJUVANT CHEMOTHERAPY
300	INDUCTION CHEMOTHERAPY
301	CONSOLIDATION CHEMOTHERAPY
302	MAINTENANCE CHEMOTHERAPY
303	HDR BRACHYTHERAPY
OPERATIONS ON THE SALIVARY GLANDS & SALIVARY DUCTS	
304	INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
305	EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
306	RESECTION OF A SALIVARY GLAND
307	RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
308	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
OPERATIONS ON THE SKIN & SUBCUTANEOUS TISSUES	
309	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
310	SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
311	LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
312	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
313	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
314	FREE SKIN TRANSPLANTATION, DONOR SITE
315	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
316	REVISION OF SKIN PLASTY
317	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTAEOUS TISSUES
318	CHEMOSURGERY TO THE SKIN
319	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
320	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
321	EXCISION OF BURSIRTIS
322	TENNIS ELBOW RELEASE

OPERATIONS ON THE TONGUE	
323	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
324	PARTIAL GLOSSECTOMY
325	GLOSSECTOMY
326	RECONSTRUCTION OF THE TONGUE
327	OTHER OPERATIONS ON THE TONGUE
OPTHALMOLOGY RELATED	
328	SURGERY FOR CATARACT
329	INCISION OF TEAR GLANDS
330	OTHER OPERATIONS ON THE TEAR DUCTS
331	INCISION OF DISEASED EYELIDS
332	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
333	OPERATIONS ON THE CANTHUS AND EPICANTHUS
334	CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
335	CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
336	REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
337	REMOVAL OF A FOREIGN BODY FROM THE CORNEA
338	INCISION OF THE CORNEA
339	OPERATIONS FOR PTERYGIUM
340	OTHER OPERATIONS ON THE CORNEA
341	REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
342	REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
343	REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
344	CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
345	CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
346	DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
347	ANTERIOR CHAMBER PARACENTESIS/CYCLODIATHERMY/CYCLOCRYOTHERAPY/ GONIOTOMY/TRABECULOTOMY AND FILTERING AND ALLIEDOPERATIONS TO TREAT GLAUCOMA
348	ENUCLEATION OF EYE WITHOUT IMPLANT
349	DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
350	LASER PHOTOCOAGULATION TO TREAT RETINAL TEAR
351	BIOPSY OF TEAR GLAND
352	TREATMENT OF RETINAL LESION

ORTHOPEDICS RELATED	
353	SURGERY FOR MENISCUS TEAR
354	INCISION ON BONE, SEPTIC AND ASEPTIC
355	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
356	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
357	REDUCTION OF DISLOCATION UNDER GA
358	ARTHROSCOPIC KNEE ASPIRATION
359	SURGERY FOR LIGAMENT TEAR
360	SURGERY FOR HEMOARTHROSIS/PYOARTHROSIS
361	REMOVAL OF FRACTURE PINS/NAILS
362	REMOVAL OF METAL WIRE
363	CLOSED REDUCTION ON FRACTURE, LUXATION
364	REDUCTION OF DISLOCATION UNDER GA
365	EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
366	EXCISION OF VARIOIUS LESIONS IN COCCYX
367	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
368	CLOSED REDUCTION OF MINOR FRACTURES
369	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
370	TENDON SHORTENING
371	ARTHROSCOPIC MENISCECTOMY-KNEE
372	TREATMENT OF CLAVICLE DISLOCATION
373	HAEMARTHROSIS KNEE-LAVAGE
374	ABSCESS KNEE JOINT DRAINAGE
375	CARPAL TUNNEL RELEASE
376	CLOSED REDUCTION OF MINOR DISLOCATION
377	REPAIR OF KNEE CAP TENDON
378	ORIF WITH K WIRE FIXATION-SMALL BONES
379	RELEASE OF MIDFOOT JOINT
380	ORIF WITH PLATING-SMALL LONG BONES
381	IMPLANT REMOVAL MINOR
382	K WIRE REMOVAL
383	POP APPLICATION
384	CLOSED REDUCTION AND EXTERNAL FIXATION
385	ARTHROTOMY HIP JOINT

386	SYME'S AMPUTATION
387	ARTHROPLASTY
388	PARTIAL REMOVAL OF RIB
389	TREATMENT OF SESAMOID BONE FRACTURE
390	SHOULDER ARTHROSCOPY/SURGERY
391	ELBOW ARTHROSCOPY
392	AMPUTATION OF METACARPAL BONE
393	RELEASE OF THUMB CONTRACTURE
394	INCISION OF FOOT FASCIA
395	CALCENUM SPUR HYDROCORT INJECTION
396	GANGLION WRIST HYALASE INJECTION
397	PARTIAL REMOVAL OF METATARSAL
398	REPAIR/GRAFT OF FOOT TENDON
399	REVISION/REMOVAL OF KNEE CAP
400	AMPUTATION FOLLOW-UP SURGERY
401	EXPLORATION OF ANKLE JOINT
402	REMOVE/GRAFT LEG BONE LESION
403	REPAIR/GRAFT ACHILLES TENDON
404	REMOVE OF TISSUE EXPANDER
405	BIOPSY ELBOW JOINT LINING
406	REMOVAL OF WRIST PROSTHESIS
407	BIOPSY FINGER JOINT LINING
408	TENDON LENGTHENING
409	TREATMENT OF SHOULDER DISLOCATION
410	LENGTHENING OF HAND TENDON
411	REMOVAL OF ELBOW BURSA
412	FIXATION OF KNEE JOINT
413	TREATMENT OF FOOT DISLOCATION
414	SUREGERY OF BUNION
415	INTRA ARTICULAR STERIOD INJECTION
416	TENDON TRANSFER PROCEDURE
417	REMOVAL OF KNEE CAP BURSA
418	TREATMENT OF FRACTURE OF ULNA
419	TREATMENT OF SCAPULA FRACTURE
420	REMOVAL OF TUMOR OF ARM/ELBOW UNDER RA/GA

421	REPAIR OF RUPTURED TENDON
422	DECOMPRESS FOREARM SPACE
423	REVISION OF NECT MUSCLE (TORTICOLLIS RELEASE)
424	LENGTHENING OF THIGH TENDONS
425	TREATMENT FRACTURE OF RADIUS & ULNA
426	REPAIR OF KNEE JOING
CARDIOLOGY RELATED	
427	CORONARY ANGIOGRAM
OTHER OPEARATIONS ON THE MOUTH & FACE	
428	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
429	INCISION OF THE HARD AND SOFT PALATE
430	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
431	INCISON, EXCISION AND DESTRUCTION IN THE MOUTH
432	OTHER OPERATIONS IN THE MOUTH
PEDIATRIC SURGERY RELATED	
433	EXCISION OF FISTULA IN ANO
434	EXCISION JUVENILE POLYPS RECTUM
435	VAGINOPLASTY
436	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
437	PRESACRAL TERA TOMAS EXCISION
438	REMOVAL OF VESICAL STONE
439	EXCISION SIGMOID POLYP
440	STERNOMASTOID TENOTOMY
441	INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
442	EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
443	MEDIASTINAL LYMPH NODE BIOPSY
444	HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
445	EXCISION OF CERVICAL TERATOMA
446	RECTAL MYOMECTOMY
447	RECATAL PROLAPSE (DELORME'S PROCEDURE)
448	DETORSION OF TORSION TESTIS
449	EUA+BIOPSY MULTIPLE FISTULA IN ANO
450	CYSTIC HYGROMA-INJECTION TREATMENT
PLASTIC SURGERY RELATED	

451	CONSTRUCTION SKIN PEDICLE FLAP
452	GLUETEAL PRESSURE ULCER-EXCISION
453	MUSCLE-SKIN GRAFT, LEG
454	REMOVAL OF BONE FOR GRAFT
455	MUSCLE-SKIN GRAFT DUCT FISTULA
456	REMOVAL CARTILAGE GRAFT
457	MYOCUTAEOUS FLAP
458	FIBRO MYOCUTANEOUS FLAP
459	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
460	SLING OPERATION FOR FACIAL PALSY
461	SPLIT SKIN FRAFTING UNDER RA
462	WOLFE SKIN GRAFT
463	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
THORACIC SURGERY RELATED	
464	THORACOSCOPY AND LUNG BIOPSY
465	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
466	LASER ABLATION OF BARRETT'S OESOPHAGUS
467	PLEURODESIS
468	THORACOSCOPY AND PLEURAL BIOPSY
469	EBUS+BIOPSY
470	THORACOSCOPY LIGATION THORACIC DUCT
471	THORACOSCOPY ASSISTED EMPYAEME DRAINAGE
UROLOGY RELATED	
472	HAEMODIALYSIS
473	LITHOTRIPSY/NEPHORLITHOTOMY FOR RENAL CALCULUS
474	EXCISION OF RENAL CYST
475	DRAINAGE OF PYONEPHROSIS/PERINEPHRIC ABSCESS
476	INCISION OF THE PROSTATE
477	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
478	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
479	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
480	RADICAL PROSTATOVESICULECTOMY
481	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
482	OPERATION ON THE SEMINAL VESICLES
483	INCISION AND EXCISION OF PERIPROSTATIC TISSUE

484	OTHER OPEATIONS ON THE PROSTATE
485	INCISION OF THE SCROTUM AND TUNICA VAGINALS TESTIS
486	OPERATION ON A TESTICULAR HYDROCELE
487	EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
488	OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
489	INCISION OF THE TESTES
490	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
491	UNILATERAL ORCHIDECTOMY
492	BILATERAL ORCHIDECTOMY
493	SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
494	RECONSTRUCTION OF THE TESTIS
495	IMPLANTATION EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
496	OTHER OPRATIONS ON THE TESTIS
497	EXCISION IN THE AREA OF THE EPIDIDYMIS
498	OPERATIONS ON THE FORESKIN
499	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
500	AMPUTATION OF THE PENIS
501	OTHER OPERATOINS ON THE PENIS
502	CYSTOSCOPICAL REMOVAL OF STONES
503	CATHETERISATION OF BLADDER
504	LITHOTRIPSY
505	BIOPSY OF TERMPORAL ARTERY FOR VARIOUS LESIONS
506	EXTERNAL ARTERIO-VENOUS SHUNT
507	AV FISTULA-WRIST
508	URSL WITH STENTING
509	URSL WITH LITHOTRIPSY
510	CUSTOSCOPIC LITHOLAPAXY
511	ESWAL
512	BLADDER NECT INCISION
513	CYSTOSCOPY & BIOPSY
514	CYSTOSCOPY AND REMOVAL OF POLYP
515	SUPRAPUBIC CYSTOSTOMY
516	PERCUTANEOUS NEPHROSTOMY
517	CYSTOSCOPY AND SLING PROCEDURE
518	TUNA-PROSTATE

519	EXCISION OF URETHRAL DIVERTICULUM
520	REMOVAL FO URETHRAL STONE
521	EXCISION OF URETHRAL PROLAPSE
522	MEGA-URETER RECONSTRUCTION
523	KIDNEY RENOSCOPY AND BIOPSY
524	URETER ENDOSCOPY AND TREATMENT
525	VESICO URETERIC REFLUX CORRECTION
526	SURGERY FOR PELVI URETERIC JUNCTION OBSTRUCTION
527	ANDERSON HYNES OPERATION
528	KIDNEY ENDOSCOPY AND BIOPSY
529	PARAPHIMOSIS SURGERY
530	INJURY PREPUCE-CIRCUMCISION
531	FRENULAR TEAR REPAIR
532	MEATOTOMY FOR MEATAL STENOSIS
533	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
534	SUREGERY FILARIAL SCROTUM
535	SURGERY FOR WATERING CANPERINEUM
536	REPAIR OF PENILE TORSION
537	DRAINAGE OF PROSTATE ABSCESS
538	ORCHIECTOMY
539	CYSTOSCOPY AND REMOVAL OF FB

Annexure 2 (attached to and forming part of policy wordings)

LIST I-ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY	
Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL/INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS

11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICES CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISON CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AID CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARM SLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR

45	KNEE BRACES (LONG/SHORT/HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDER LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (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	TOOTH PASTE
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	PULSEOXYMETER CHARGES
LIST III-ITEM 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	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV-ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/CAPD EQUIPMENTS
7	INFUSION PUMP-COST
8	HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES-DIETICIAN CHARGES-DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM

17	GLUCOMETER & STRIPS
18	URINE BAG

9. 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.

10. 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.

a. Tele-consultation, In person consultation and Prescription Diagnostics taken outside the Digital platform is not covered under the Add-on cover

b. 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.

c. Disease arising out of involvement in illegal activities or substance abuse.

d. Treatment other than Allopathy and AYUSH*.

e. Inpatient treatments & day-care procedures are not covered under the policy.

f. No medical equipment and associated consumables will be covered under the policy (Example – BP Machine, Thermometer, Syringes, Nebulizer, Hot Water Bags, etc.)

g. Vitamins and tonics used for the treatment of injury or disease will not be covered

h. Food, Food Supplements or Dietary Pills (Example – Horlicks, Glucose, Whey Protein, etc.).

i. Non-Medical Expenses - Registration Fee, Admission Fee, Telephone Charges, Cafeteria Charges, etc..

j. Consultation with Nutritionists - Available only online through the digital platform.

k. 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.

11. Home Care Treatment – Add on Cover

(on payment of additional premium)

UIN:CHOHLIA22201V012122

1. GENERAL CONDITIONS

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

2. SUM INSURED

a. Daily limit options – Rs.1000/- to Rs. 10,000/- per day in multiples of Rs.500/-

b. Number of days – 5 / 7 / 10 / 15 / 20 / 25 / 30 / 45 / 60 days per annum

c. This add-on cover can be availed on Individual or Family floater basis

d. On Individual basis, it is our maximum liability for each Insured Person for any and all benefits claimed for during the Annual Period (i.e. per annum for multi-year tenure) within the policy period, unless otherwise specified and

e. In relation to a Family Floater, it is our maximum liability for any and all claims made by all the Insured persons during the Annual Period (i.e. per annum for multi-year tenure) within the Policy period, unless otherwise specified.

f. Sum Insured Restoration, if any available under Base Policy shall not be applicable for Home care Treatment under this Add-on cover.

3. DEFINITIONS

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

a. Ho**mecare 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.

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*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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Medical Second Opinion-Add-on Cover UIN: CHOHLIA19048V011920
Flexi OP Care-Add-on Cover UIN: CHOHLIA23045V012223
Home Care Treatment (Retail) Add-on Cover UIN: CHOHLIA22201V012122
CMS/HEALTH/FH/PWBOOKLET/ENG/3835/OCT2024