#pledge2protect™

Chola MS
GENERAL INSURANCE

TOPUP YOUR HEALTH INSURANCE,
THE FLEXI WAY.

INTRODUCING

CHOLA FLEXI SUPER TOPUP INSURANCE

REACH US THROUGH WHATSAPP

7305234433

Dear Customer,

Life entails making crucial decisions, especially in matters of health, because the right insurance policy correlates directly with the financial security of your family.

However, making these critical insurance choices over and over again amidst surmounting difficulties requires consistent planning and a whole lot of flexibility.

After a thorough understanding of the nature of your evolving needs, we at Chola MS present the Chola Flexi Super Topup Insurance Policy – which provides coverage for higher medical expenses for families on a floating sum insured basis or on an individual sum insured basis.

With Chola Flexi Super Topup Insurance Policy, you can pay a part of the standard health insurance premium, and get complete coverage along with a host of other benefits:

- Cover for Extended Family
- Cover for AYUSH Treatments
- Life-long Renewability
- No Sub-limits or Co-payments
- Flexibility to top up your health policy for additional coverage
- Sum insured range upto 5 Crores with deductible options upto 1 Crore
- Direct Claim Settlement

Available as Gold Plan & Silver Plan variants, the policy covers day care procedures, pre and pre-hospitalization expenses among others.

This means that you do not have to spend another day worrying about your sum insured getting exhausted or taking another expensive insurance plan.

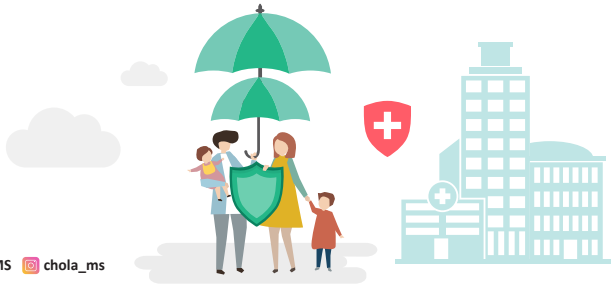
Over the past 20 years, it has been our mission to protect you and your loved ones in times of need, and arm you with flexible insurance products that bring about mental peace and financial stability.

I wish you continued good health, happiness and wellness and trust that you would #StayHealthy, #StayInsured and protect your loved ones too.

A life of complete and continuous security can now be yours. Take it into your hands!

Warm Regards...

V. SURYANARAYANAN
Managing Director



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POLICY WORDINGS

1. Definitions 03
2. Schedule of Benefits 11
3. Coverages 14
4. Waiting Periods 16
5. Exclusions 18
6. General Conditions 20
7. Grievance Redressal Mechanism 30
8. Annexure 1 39
9. Annexure 2 43

POLICY WORDINGS

Chola Flexi Super Topup Insurance

UIN: CHOHLIP23049V022223

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 / Accidental** means a 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. **Admissible Claim Amount** means the eligible amount payable under this policy, to You, upto the Sum Insured, after applying the Deductible and sublimits wherever applicable.

4. **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.

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

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 Service/Facility** means a service / facility extended by the Company 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 Company to the extent pre-authorization approved.

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

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

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

14. **Congenital Anomaly** refer to a condition(s) which is present since birth, which is abnormal with reference to form, structure or position-

    a. **Internal Congenital Anomaly:** Congenital anomaly which is not in the visible and accessible parts of the body.

    b. **External Congenital Anomaly:** Congenital anomaly which is in the visible and accessible parts of the body.

15. **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

    a. Has qualified nursing staff under its employment;

    b. Has qualified medical practitioner/s in charge;

    c. Has a fully equipped operation theatre of its own where surgical procedures are carried out;

    d. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

16. **Day Care Treatment** refers to medical treatment and / or surgical procedure which is

    a. Undertaken under general or local anesthesia in a hospital / day care centre in less than 24 hours because of technological advancement and

    b. Which would have otherwise required hospitalization of more than 24 hours Treatment normally taken on an out-patient basis is not included in the scope of this definition.

17. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days / hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured. Deductible will apply over aggregate of all admissible claims under the policy per annum by insured (individual policy) or insured family (in case of floater policy).

18. **Dependents** means only the family members / extended family members listed below, who is related to Primary Insured or proposer.

    a. Your legally married Spouse as long as he or she continues to be married to you

    b. Your legal Children.

    c. Your natural parents or parents that have legally adopted you

    d. Parents in Laws as long as your spouse continues to be married to you

    e. Grand Father, Grand Mother, Grand Son, Grand Daughter, Daughter in Law, Son in Law, Sister, Brother in Law, Brother, Sister in Law, Nephew, Niece.

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

20. **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.

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

22. **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.

23. **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.

24. **Emergency Care** means management for a severe 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.

25. **Endorsement** 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.

26. **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.

27. **Family** means and includes You, Your legally married Spouse, Your Children and Dependant Parents.

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 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.

30. **Hospital** means any institution established for in-patient care and day care treatment of disease and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    a. has qualified nursing staff under its employment round the clock;
    b. has at least ten in-patient beds in towns having a population of less than ten lakhs and at least fifteen in-patient beds in all other places;
    c. has qualified Medical Practitioner(s) in charge round the clock;
    d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e. 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. **Identification or ID card** means the card issued to You by us.

33. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

    a. **Acute condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / illness / injury which leads to full recovery.

    b. **Chronic condition** means a disease, illness, or injury that has one or more of the following characteristics:
        i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests.
        ii. it needs ongoing or long-term control or relief of symptoms.
        iii. it requires rehabilitation for the patient or for the patient to be special trained to cope with it.
        iv. it continues indefinitely.
        v. it recurs or is likely to recur.

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

35. **In-patient Care** means treatment for which the Insured Person has to stay in a

hospital for more than 24 hours for a covered event.

36. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

37. **ICU Charges** (Intensive Care Unit) charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

39. **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.

40. **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.

41. **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.

42. **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.

43. **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.

44. **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.

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

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

47. **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.

48. **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.

49. **Policy period** means the period between the inception date and earlier of
    a. The Expiry Date specified in the Schedule
    b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (6.15) below.
    c. In a multi Tenure Policy, a policy year would be reckoned from the date of inception to 12 months of continuous cover.

50. **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.

51. **Portability** 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.

52. **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.

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. **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.

55. **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.

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

57. **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.

58. **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.

59. **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.

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

61. **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.

62. **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.

63. **Sum Insured** means the amount shown in the policy schedule which shall be our maximum liability under section 3.1 of 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. This is the actual coverage amount over and above the deductible opted by you.

64. **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 of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

2 SCHEDULE OF BENEFITS

In the event of **Insured Person** suffering from an illness or Accident during the Policy Period that requires hospitalisation on an Inpatient basis or treatment defined as a **Day Care Procedure**, then this policy will pay for the Medical Expenses for the benefits mentioned below in excess of the **Deductible** stated in the **Policy Schedule**.

The **deductible** will apply over aggregate of all admissible claims under the policy per annum.

In case of Individual Cover, the deductible will be applied over the aggregate of all the admissible claims made by the **Insured Person**.

In case of Family Floater Cover, the deductible will be applied over the aggregate of all the admissible claims made by all **Insured Persons** in the family.

PLANS	SILVER	GOLD
In Patient Hospitalisation Expenses	Covered	Covered
Pre-Hospitalisation Expenses	Not Covered	60 days
Post-Hospitalisation Expenses	Not Covered	90 days

PLANS	SILVER	GOLD
Emergency Ambulance Expenses	Covered	Covered
Day Care Procedures	Covered	Covered
Domiciliary Hospitalisation	Covered	Covered
AYUSH Coverage Expenses	Covered	Covered

PLANS	SILVER	GOLD
Expenses considered for aggregate deductible	In Patient Hospitalisation Expenses	In Patient Hospitalisation Expenses
	Emergency Ambulance Expenses	Pre-Hospitalisation Expenses
	Day Care Procedures	Post-Hospitalisation Expenses
	Domiciliary Hospitalisation	Emergency Ambulance Expenses
	AYUSH Coverage Expenses	Day Care Procedures
		Domiciliary Hospitalisation
		AYUSH Coverage Expenses
WAITING PERIOD		
Initial waiting period of 30 days	Applicable	Applicable
Specific waiting period Applicable	12 months	12 months
Waiting period for Pre existing Disease	36 months	36 months
SUM INSURED OPTIONS AVAILABLE UNDER BOTH PLANS OF THE POLICY		
Sum Insured (SI) Options (in lacs)	**Deductible Options (in lacs)**	
5	5/10	
7.5	5/7.5	
10	5/7.5/10	
15	5/10	
20	5/10/15	
From Rs.25 Lacs to Rs.45 Lacs in multiples of Rs.5 Lacs	Rs.5 Lacs to Rs.20 lacs in multiples of Rs.5 Lacs	
50	5/10/15/20/25	
75	Rs.10 Lacs to Rs.50 lacs in multiples of Rs.5 Lacs	

PLANS	SILVER	GOLD
90	10	
92.5	7.5	

PLANS	SILVER	GOLD
95	5	
From Rs.1 Crore to Rs.5 Crores in multiples of Rs.50 Lacs	Rs.15 Lacs to Rs.1 Crore in multiples of Rs.5 Lacs	

The benefit applicable to you will depend on the Plan and Sum Insured opted by you as shown in your **Policy Schedule**.

Note:

In case of Individual cover, the benefits shown in the table above will represent our maximum liability for each **Insured Person** for any and all claims made during the Annual Period (i.e. per annum for multi year tenure) within the **policy period**.

In case of **Family floater** cover, the benefits shown in the table above will represent our maximum liability for any and all claims made by all Insured person(s) in the family during the Annual Period (i.e. per annum for multi year tenure) within the policy period.

Illustration				
Sum Insured opted by the Insured	Rs.5,00,000/-			
Deductible opted	Rs.3,00,000/-	Deductible will apply over aggregate of all admissible claims under the policy per annum by insured (Individual cover) or insured family (in case of Family Floater cover).		
Policy Period	01-Jan-2020 to 31-Dec-2020			
Individual Cover				
Claim	**Month**	**Claim Amount**	**Deductible Applicable**	**Claim admissible under Chola Flexi Super Topup Insurance**
1	June	Rs.150000/-	Rs.150000/-	Nil
2	September	Rs.250000/-	Rs.150000/-	Rs.1,00,000/-
Total		**Rs.400000/-**	**Rs.300000/-**	
Family Floater Cover				

Claim	Month	Claim Amount	Deductible Applicable	Claim admissible under Chola Flexi Super Topup Insurance
1 - Insured 1	April	Rs.75000/-	Rs.75000/-	Nil
2 - Insured 3	August	Rs.200000/-	Rs.200000/-	Nil
3 - Insured 4	November	Rs.400000/	Rs.25000/-	Rs.375000/-
Total		**Rs.675000/-**	**Rs.300000/-**	

3. COVERAGES

3.1. Coverage

3.1.1 **Inpatient 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, medical condition or injury contracted or sustained by the insured person during the Policy Period as stated in the policy Schedule subject to deductibles, terms, conditions and exclusions mentioned in the Policy.

a. Room, Boarding ,ICU charges as provided by the Hospital / Nursing Home
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.
f. Hospitalisation expenses of the Organ donor during the stay as in-patient solely for the purpose of harvesting the organ, excluding pre and post hospitalisation expenses for such donor.

3.1.2 **Pre Hospitalisation Expenses (Applicable under plan GOLD):**

This Policy will pay for medical expenses incurred upto 60 days prior to the date of Hospitalisation subject to deductible provided that

a. The expenses were incurred after the first 30 day waiting period as mentioned in Waiting Period no 4.1
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.

3.1.3 **Post Hospitalisation Expenses (Applicable under plan GOLD):**

This Policy will pay for medical expenses incurred upto 90 days from the date of discharge from the hospital subject to deductible 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.

3.1.4 **Emergency Ambulance Expenses:**

This Policy will pay for Road Ambulance Expenses actually 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) The Inpatient Hospitalisation claim for such Hospitalisation is admissible by Us

Ambulance Expenses will be reimbursed to the Insured on submission of original bills. Cashless facility will not be available for Ambulance Expenses / Services. Payment under this benefit will reduce the Sum Insured.

3.1.5 **Day Care Procedures:**

This Policy will pay for Medical Expenses incurred as a Day Care Procedure / Treatment for the 141 list of procedures / treatment that requires less than 24 hours of hospitalisation, upto Sum Insured in excess of deductible mentioned in the policy schedule if it is performed in a network hospital. In case the procedure is performed in a non network hospital, the same must be pre-authorised by us.

Payment under this benefit will reduce the Sum Insured.

3.1.6 **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 and Post hospitalisation expenses in accordance with Section 3.1.2 & 3.1.3 (Applicable under Plan GOLD) will be covered under this benefit. No payment will be made under this benefit if the condition for which the Insured Person requires medical treatment towards following ailments:

1. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza

2. Arthritis, Gout and Rheumatism,
3. Chronic Nephritis and Nephritic Syndrome,
4. Diarrhoea and all type of Dysenteries including Gastroenteritis,
5. Diabetes Mellitus and Insupidus,
6. Epilepsy,
7. Hypertension,
8. Pyrexia of unknown Origin.

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

3.1.7 ***AYUSH Coverage Expenses:**

This Policy will pay for non-allopathic treatments that require more than 24 hrs of Hospitalization and Day care procedures for illness or accidental bodily injury sustained by the Insured upto Sum Insured in excess of deductible as mentioned 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. Waiting Period

4.1 **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.

4.2 **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 12 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
   b. Varicose veins and Varicose Ulcers
   c. Knee Replacement Surgery (other than caused by an Accident), Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis
   d. Treatment of diseases on ears / tonsils / adenoids / paranasal sinuses / Deviated Nasal Septum
   e. Stones in the Urinary and Biliary systems
   f. Gastric or Duodenal Ulcer
   g. Any type of benign Cyst / Nodules / Polpys / Tumours / Breast Lumps
   h. Prolapse of Inter-vertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylitis, Spondylolisthesis etc.
   i. Cataract
   j. Benign Prostatic Hypertrophy
   k. Myomectomy, Hysterectomy unless because of malignancy
   l. Dilatation and curettage (D&C)
   m. Anal Fistula, Fissure and Piles
   n. All types of Hernia
   o. Hydrocele
   p. Chronic Renal Failure
   q. Joint replacement Surgery unless because of accident

4.3 **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 the norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by the Insurer.

5. Exclusions

5.1 **Deductible:**

The Company will not be liable for claims/claim amount falling within deductible limit as opted and mentioned on the Policy Schedule.

5.2 **General Exclusion:**

The Company will not pay for any claim in respect of any Insured Person directly for, caused by, arising from or in any way attributable to:

5.2.1 **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.

5.2.2. **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:

b. 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.

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

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

1. Surgery to be conducted is upon the advice of the doctor
2. The surgery / procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
    a. Greater than or equal to 40 or
    b. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related Cardiomyopathy
        ii. Coronary Heart Disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type 2 Diabetes

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

5.2.5 **Cosmetic or plastic Surgery: Code –Excl-08:** 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.

5.2.6 **Hazardous or Adventure Sports: Code–Excl 09:** 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.

5.2.7 **Breach of Law: Code–Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent and intentional self-injury or attempted suicide whether sane or insane.

5.2.8 **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.

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

5.2.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code–Excl 13)**

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

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

5.2.13 **Unproven Treatments: Code–Excl 16:** 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.

5.2.14 **Sterility and Infertility: Code–Excl 17:** Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational surrogacy

iv. Reversal of sterilization

5.2.15 **Maternity Expenses: Code–Excl 18:**

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.

5.2.16 Congenital anomaly / illness / diseases / condition which are external.

5.2.17 Pre & Post hospitalisation expenses of the organ donor and consequential loss to such organ donor.

5.2.18 Injury / illness directly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (whether war be declared or not), ionising radiation, contamination by Radioactive material, nuclear fuel or nuclear waste or from the combustion of nuclear fuel, civil war, revolution, insurrection, mutiny, martial law.

5.2.19 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.

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

5.2.21 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.

5.2.22 Conditions for which treatment could have been done on an OPD basis without any Hospitalisation and Outpatient treatment.

5.2.23 Vaccination or inoculation and immunisations (except in case of post-bite treatment).

5.2.24 Any treatments or Investigation taken outside India.

5.2.25 Treatment other than Allopathy and AYUSH*.

5.2.26 Non medical Expenses incurred during Hospitalisation. The list of such Non medical Expenses is placed at Annexure1.

6. 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 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 by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal / enrolment 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.

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 Policy**

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

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days written notice. There would be no refund of premium on cancellation of grounds of misrepresentation, non-disclosure of material facts or fraud.condition precedent to our liability that You shall immediately:

16 **Deductible**

Deductible is a cost sharing requirement under this Policy that provides that the Company will not be liable for medical expenses upto a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured. Deductible opted as per the Policy Schedule will apply over aggregate of all admissible claims under the policy per annum by insured (Individual cover) or insured family (in case of Family Floater cover).

17 **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.

18 **Cost of pre-insurance health checkup**

Based on acceptance of the proposal and issuance of policy, we would reimburse to the insured 100% of the cost of examinations as per the plan selected. This will be provided as refund of expenses for pre-policy health check-up to the proposer after policy issuance.

Original receipt for medical tests undergone is required to be submitted to us for reimbursement. This has to be claimed within 30 days of approval of policy.

19 **Misdescription**

In the event of misrepresentation, mis-description or non-disclosure of any material fact by the Insured person(s), the policy shall be void and all premium paid hereon shall be forfeited to the Company and no claim shall be payable under the policy.

20 **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). 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.

A specific exclusion with waiting period may be applied on a medical condition / disease

depending on the medical test done based on the Proposed Insured person's medical history and declarations as part of special conditions on the Policy with due consent from the policyholder.

21 **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 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 Schedule.

22 **Transfer**

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

23 **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.

24 **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.

25 **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.

26 **Assignment**

The policy can be assigned subject to applicable laws.

27 **Claim Procedure**

If the Insured Person(s) suffer from Accidental Bodily Injury or is diagnosed with an Illness which gives rise to or may give rise to a claim under this policy, then it is a condition precedent to our liability that the Insured shall immediately:

a. Give us notice of the claim at the earliest irrespective of notice provided to any other insurer for the same illness in case the Insured Person(s) hold 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 us

c. If the Insured has any other insurance policy in addition to this Super Topup Insurance as on the date of claim which also covers any claim (in part or in whole) being made under this policy, then the Insured will have the right to require a settlement of his claim in terms of any of his policies. The insurer

chosen by the Insured shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen policy.

Provided further that, if the amount to be claimed under the policy chosen by the Insured, exceeds the sum insured under the policy after considering the deductibles or co-pay (if applicable), the insured shall have the right to choose the insurers from whom he/she wants to claim the balance amount. In such cases the respective insurers shall indemnify the hospitalisation costs in accordance with the terms and conditions of the chosen policy.

d. If the Insured make the first claim from the primary insurer and have not intimated Us immediately along with the other Insurer expecting that the total claim would not exceed the sum insured limit of such insurance, it would not amount to delayed intimation provided however that the Insured intimate Us immediately when the cost of treatment is likely to exceed the deductible amount under this policy or before the discharge, whichever is earlier.

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

27.1 **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. Pre-authorisation request shall, if we are satisfied as to the validity of the claim, specify

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

27.2 **Reimbursement Claims**

1. Upon Hospitalisation, the Insured Person or his/her dependents shall provide us with fully particularised details of the quantum of the claim to be reimbursed and all other information and documentation in respect of the claim and/ or our liability as listed below 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 the 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 the Insured or his/her 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 the Insured, it being agreed and recognised by the Insured that we are not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution (including a Network Hospital) whether pre-authorised or not.

6. Following documents are to be submitted for processing of the claim:

a. Claim Form duly filled and signed by patient/ Insured.
b. 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
c. Original Main bill from the hospital with cost wise break up.
d. Original payment receipt (Receipt should have Serial No)
e. 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.
f. 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.

g. Implant stickers or invoice where ever applicable

h. In case of Road traffic accident (RTA), copy of FIR and/or Medico legal Certificate (MLC) would be required.

i. AML documents in case the claimed amount is above 1 lac

j. Bank details along with the cancelled cheque for claim payment through NEFT

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted to us.

Our Customer Support and Claims Office contact details are as detailed below for the purpose of claim intimation, submission or for any queries / grievances:

Chola MS customer support operates 24/7 basis and the contact details are:

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

Address of Chola MS Health Claims Office:

Cholamandalam MS General Insurance Company Limited

Chola MS HELP – Health Claims Department

New No.2, Old No. 234, Parry House, 3rd Floor,

N. S. C. Bose Road, Chennai - 600001.

Customer Care Toll Free No: 1800-208-9100

E-Mail: customercare@cholams.murugappa.com

27.3 **TPA**

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

27.4 **Delay in intimation of claim**

It is essential and imperative that any loss or claim under the policy has to be intimated 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 the Insured's control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Insured's 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 the 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 **Enhancement of Sum Insured or Deductible**

Sum insured or Deductible can be enhanced only at the time of renewal subject to reported claim status and health condition of the insured. If the Insured decides to increase the Sum Insured or Deductible at the time of renewal, subject to our acceptance, then the coverage for the increased Sum Insured shall be as if a new policy is issued for the additional Sum Insured. The additional Sum Insured will be available subject to 30 day, 1 year and 3 year / 4 year (waiting period of pre-existing condition) waiting periods 4.1, 4.2 and 4.3 of the Policy Terms.

Sum Insured Enhancement will not be considered for

a. Insured Persons over 65 years of age

b. Insured Persons suffering from one or more of the following illnesses /conditions:

   i. Diabetes

   ii. Hypertension

   iii. Chronic condition as defined in the policy

30 **Automatic Termination**

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

a. 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.

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

31 **Disclaimer**

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

7. GRIEVANCES REDRESSAL MECHANISM

Website : www.cholainsurance.com

Toll free : 1800 208 9100

E-Mail : customercare@cholams.murugappa.com

Courier : Manager , Customer Care, Chola MS General Insurance Company Limited Hari Nivas Towers First Floor, #163, Thambu Chetty Street, Parry's Corner, Chennai -600001

Procedure of Grievance Redressal

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

Escalation Matrix

- In case you are dissatisfied with the response or have not received a response, you may escalate the same to our Nodal Officer – Nodalescalation@cholams.murugappa.com (Quoting the previous Service request number)
- In case you are still unhappy with the response or have not received a response within 7 working days, you may escalate the same to our Chief Grievance Officer - GRO@cholams.murugappa.com (Quoting the previous Service request number)
- If after having followed the above steps and your issue still remain unresolved, you may approach the Insurance Ombudsman for Redressal. Login to https://www.cioins.co.in/Ombudsman to get details on Insurance Ombudsman Offices.

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

Office Details	Jurisdiction of Office
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).

Office Details	Jurisdiction of Office
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.

Office Details	Jurisdiction of Office
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.

Office Details	Jurisdiction of Office
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

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

CHOLA FLEXI SUPER TOPUP INSURANCE -GOLD PLAN, Policy Period - ONE Year										
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	912	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	912	7.50%	6,189	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	4,794	NIL	4,794	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible
23	1035	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	1035			Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible				
48	1,949	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	1,949			Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible				
54	2,795	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	2,795			Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible				

Total premium for all members of the family is Rs. 6691/-, when each member is covered separately.	Total premium for all members of the family is Rs.6189/-, when they are covered under a single policy.	Total premium when policy is opted on floater basis is Rs.4,794/-
Sum Insured available for each individual is Rs.10 Lakhs with deductible of Rs 5 Lakhs	Sum Insured available for each family member is Rs.10 Lakhs with deductible of Rs 5 Lakhs	Sum Insured of Rs.10 Lakhs with deductible of Rs 5 Lakhs is available for the entire family
Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.		

CHOLA FLEXI SUPER TOPUP INSURANCE -GOLD PLAN, Policy Period - ONE Year

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	1,268	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	1,268	7.50%	11,821	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	Children not covered above 26 years of age			
61	4,759	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	4,759			Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	10,129	NIL	10,129	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible
66	6,752	Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible	6,752			Rs 10 Lakhs Sum insured with Rs 5 Lakhs Deductible				

Total premium for all members of the family is Rs. 12,779/-, when each member is covered separately.	Total premium for all members of the family is Rs.11,821/-, when they are covered under a single policy.	Total premium when policy is opted on floater basis is Rs.10,129/-
Sum Insured available for each individual is Rs.10 Lakhs with deductible of Rs 5 Lakhs	Sum Insured available for each family member is Rs.10 Lakhs with deductible of Rs 5 Lakhs	Sum Insured of Rs.10 Lakhs with deductible of Rs 5 Lakhs is available for the entire family.
Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.		

8 ANNEXURE - 1 (attached to and forming part of policy wordings)

LIST I – NON MEDICAL EXPENSES EXCLUDED UNDER THE POLICY	
Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICES CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISON CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE

31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/SHORT/HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
54	CREAMS POWDER LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHO KIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU0DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTHPASTE
13	TOOTHBRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ADMINISTRATIVE EXPENSE
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE

34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES/MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND/NAME TAG
37	PULSE OXIMETER CHARGES
LIST III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1	HAIR REMOVAL CREAM
2	DISPOSABLE RAZORS CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD, CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TOURNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES

5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP – COST
8	HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES – DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABS
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

9 ANNEXURE - 2 LIST OF DAY CARE PROCEDURES

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

15	Fenestration of the inner ear
16	Revision of a fenestration of the inner ear
17	Incision (opening) and destruction (elimination) of the inner ear
18	Other operations on the middle and inner ear
Operations on the nose and the nasal sinuses	
19	Excision and destruction of diseased tissue of the nose
20	Operations on the turbinates (nasal concha)
21	Other operations on the nose
22	Nasal sinus aspiration
Operations on the eyes	
23	Incision of tear glands
24	Other operations on the tear ducts
25	Incision of diseased eyelids
26	Excision and destruction of diseased tissue of the eyelid
27	Operations on the canthus and epicanthus
28	Corrective surgery for entropion and ectropion
29	Corrective surgery for blepharoptosis
30	Removal of a foreign body from the conjunctiva
31	Removal of a foreign body from the cornea
32	Incision of the cornea
33	Operations for pterygium
34	Other operations on the cornea
35	Removal of a foreign body from the lens of the eye
36	Removal of a foreign body from the posterior chamber of the eye
37	Removal of a foreign body from the orbit and eyeball
38	Operation of cataract
Operations on the skin and subcutaneous tissues	
39	Incision of a pilonidal sinus
40	Other incisions of the skin and subcutaneous tissues
41	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin
42	Removal of subcutaneous tissues
43	Local excision of diseased tissue of the skin and subcutaneous tissues
44	Other excisions of the skin and subcutaneous tissues

45	Simple restoration of surface continuity of the skin and subcutaneous tissues
46	Free skin transplantation, donor site
47	Free skin transplantation, recipient site
48	Revision of skin plasty
49	Other restoration and reconstruction of the skin and subcutaneous tissues
50	Chemosurgery to the skin
51	Destruction of diseased tissue in the skin and subcutaneous tissues
Operations on the mouth and face	
Operations to the tongue	
52	Incision, excision and destruction of diseased tissue of the tongue
53	Partial glossectomy
54	Glossectomy
55	Reconstruction of the tongue
56	Other operations on the tongue
	Operations on the salivary glands and salivary ducts
57	Incision and lancing of a salivary gland and a salivary duct
58	Excision of diseased tissue of a salivary gland and a salivary duct
59	Resection of a salivary gland
60	Reconstruction of a salivary gland and a salivary duct
61	Other operations on the salivary glands and salivary ducts
Other operations on the mouth and face	
62	External incision and drainage in the region of the mouth, jaw and face
63	Incision of the hard and soft palate
64	Excision and destruction of diseased hard and soft palate
65	Incision, excision and destruction in the mouth
66	Plastic surgery to the floor of the mouth
67	Palatoplasty
68	Other operations in the mouth
Operations on the tonsils and adenoids	
69	Transoral incision and drainage of a pharyngeal abscess
70	Tonsillectomy without adenoidectomy
71	Tonsillectomy with adenoidectomy
72	Excision and destruction of a lingual tonsil
73	Other operations on the tonsils and adenoids

Traumatological surgery and orthopaedics	
74	Incision on bone, septic and aseptic
75	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76	Suture and other operations on tendons and tendon sheath
77	Reduction of dislocation under GA
78	Arthroscopic knee aspiration
Operations on the breast	
79	Incision of the breast
80	Operations on the nipple
Operations on the digestive tract	
81	Incision and excision of tissue in the perianal region
82	Surgical treatment of anal fistulas
83	Surgical treatment of haemorrhoids
84	Division of the anal sphincter (sphincterotomy)
85	Other operations on the anus
86	Ultrasound guided aspirations
87	Sclerotherapy etc.
Operations on the female sexual organs	
88	Incision of the ovary
89	Insufflation of the Fallopian tubes
90	Other operations on the Fallopian tube
91	Dilatation of the cervical canal
92	Conisation of the uterine cervix
93	Other operations on the uterine cervix
94	Incision of the uterus (hysterotomy)
95	Therapeutic curettage
96	Culdotomy
97	Incision of the vagina
98	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99	Incision of the vulva
100	Operations on Bartholin's glands (cyst)
Operations on the male sexual organs	
Operations on the prostate and seminal vesicles	

101	Incision of the prostate
102	Transurethral excision and destruction of prostate tissue
103	Transurethral and percutaneous destruction of prostate tissue
104	Open surgical excision and destruction of prostate tissue
105	Radical prostatovesiculectomy
106	Other excision and destruction of prostate tissue
107	Operations on the seminal vesicles
108	Incision and excision of periprostatic tissue
109	Other operations on the prostate
Operations on the scrotum and tunica vaginalis testis	
110	Incision of the scrotum and tunica vaginalis testis
111	Operation on a testicular Hydrocele
112	Excision and destruction of diseased scrotal tissue
113	Plastic reconstruction of the scrotum and tunica vaginalis testis
114	Other operations on the scrotum and tunica vaginalis testis
Operations on the testes	
115	Incision of the testes
116	Excision and destruction of diseased tissue of the testes
117	Unilateral orchidectomy
118	Bilateral orchidectomy
119	Orchidopexy
120	Abdominal exploration in cryptorchidism
121	Surgical repositioning of an abdominal testis
122	Reconstruction of the testis
123	Implantation, exchange and removal of a testicular prosthesis
124	Other operations on the testis
Operations on the spermatic cord, epididymis und ductus deferens	
125	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126	Excision in the area of the epididymis
127	Epididymectomy
128	Reconstruction of the spermatic cord
129	Reconstruction of the ductus deferens and epididymis
130	Other operations on the spermatic cord, epididymis and ductus deferens
Operations on the penis	

131	Operations on the foreskin
132	Local excision and destruction of diseased tissue of the penis
133	Amputation of the penis
134	Plastic reconstruction of the penis
135	Other operations on the penis
Operations on the urinary system	
136	Cystoscopical removal of stones
Other Operations	
137	Lithotripsy
138	Coronary angiography
139	Haemodialysis
140	Cancer Chemotherapy
141	Radiotherapy for Cancer

*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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CHOLA FLEXI SUPER TOPUP INSURANCE

*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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