CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai – 600 001.
Toll free: 1800 208 5544, T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123; PAN AABCC6633K CIN U66030TN2001PLC047977

GROUP HEALTH INSURANCE
CHOHLGP21307V022021
POLICY WORDINGS

GROUP HEALTH INSURANCE

Contents

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

This policy will be issued as a group policy to the policy holder and individual certificate will be issued to the beneficiaries.

1. C O V E R A G E S

Upon the happening of the events under sections 1.1 to 1.5 below during the policy period, we will indemnify the policyholders in respect of medically necessary costs as detailed below, up to the limit of Indemnity as mentioned in the policy schedule and as per the General Conditions of this policy.

1.1 Inpatient Hospitalization Expenses

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

a. Room and boarding
b. Doctors' fees
c. Intensive Care Unit
d. Nursing expenses
e. Surgical fees, operating theatre, anesthesia, blood and oxygen and their administration
f. Physical therapy expenses
g. Drugs and medicines consumed on the premises
h. Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, diagnostic tests)
i. Dressing, ordinary splints and plaster casts
j. Costs of prosthetic devices if implanted during a surgical procedure
k. Organ transplantation including the treatment costs of the donor but excluding the costs of the organ

1.2 Pre-Hospitalization Expenses

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

a. The expenses were incurred after the first 30 day waiting period as mentioned in Exclusion no 1
b. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
c. The Inpatient Hospitalization claim for such Hospitalization is admissible by Us.

1.3 Post-Hospitalization Expenses covers

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

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

1.4 Emergency Ambulance Expenses

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

a. The ambulance service is offered by a healthcare or an ambulance service provider.
b. We have accepted the inpatient hospitalization claim under point 1.1 above.

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Specific Conditions Applicable to 1.1 – 1.4 inclusive:

a. The Administrator will arrange for cash free payment to the extent of the Insurer ' s liability Hospitalisation Expenses incurred at Network Hospitals subject to the Policyholder ' s satisfaction General Conditions 4.3.

b. If the Insured Person for any reason chooses not to use a Network Hospital or opts for a higher Hospitalisation Class or otherwise breaches the terms of the authorisation obtained pursuant to General Condition 3)c), then the amount payable by or on behalf of the Insurer shall be reduced as per the Co- payment Table and shall be borne by the Policyholder or Primary Insured . This clause shall not apply if due to an Illness or Accidental Bodily Injury the Insured Person requires Emergency Hospitalisation or change of Hospital so as to avoid a material risk to the Insured Person ' s life or health, and as a result the Insured Person is unable to obtain pre-authorisation provided that:

1. The Administrator is given notice of the Insured Person ' s Hospitalisation as soon as reasonably practicable, and
2. the terms of General Condition D 3) are complied with as soon as the material risk to the Insured Person ' s life or health has passed.

1.5 Day Care Procedures/Treatment Expenses

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

2. D E F I N I T I O N S

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

1. **Accident / Accidental** mean 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. **Age** means completed years on Your last birthday as per the English Calendar regardless of the actual time of birth, at the time of commencement of Policy Period.
4. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha, and Homeopathy in the Indian context.
5. **Any one illness** means continuous Period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
6. **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.
7. **Claims Team** means the Claims administration team within Chola MS General Insurance Company
8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Congenital Anomaly** means a condition which is present since birth, which is abnormal with reference to form, structure or position.
    a. **Internal Congenital Anomaly:** Congenital anomaly which is not in the visible and accessible parts of the body.
    b. **External Congenital Anomaly:** Congenital anomaly which is in the visible and accessible parts of the body.
10. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

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11. **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-
    - **i.** has qualified nursing staff under its employment;
    - **ii.** has qualified medical practitioner/s in charge;
    - **iii.** has a fully equipped operation theatre of its own where surgical procedures are carried out;
    - **iv.** maintains daily records of patients and will make these accessible to the insurance company's authorized personnel
12. **Day care treatment means medical treatment and/or surgical procedure which is**
    a. undertaken under general or local anaesthesia in a hospital / day care centre in less than 24 hours because of technological advancement and
    b. which would have otherwise required Hospitalisation of more than 24 hours
    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
13. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/ her independent sources of income
14. **Dependents** refer to family members listed below, who is financially dependent on the Primary Insured or proposer and does not have his / her independent sources of income. Spouse, dependent children, Parents, Parents-in-law.
15. **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
16. **Diagnostic Test** means investigations such as X-ray or blood tests to find the cause of Your symptoms and medical condition
17. **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.
18. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
19. **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
20. **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.
21. **Family Floater** means a Policy described as such in the Schedule where You and Your Dependents named in the Schedule are insured under this Policy. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period
22. **Grace period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of preexisting diseases. Coverage is not available for the period for which no premium is received.
23. **Group:** A group should consist of persons who assemble together with a commonality of purpose or engaging in a common economic activity like employees of a company. It includes non employer–employee groups, like members of employee welfare associations, holders of credit/debit cards issued by a specific company, customers of a particular business where insurance may also be offered as an add on benefit, , borrowers of a bank/ financial companies/ co-operative societies, professional associations or societies.
24. **Hospital** means any institution established for inpatient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    - **i.** has qualified nursing staff under its employment round the clock;

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

25. **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 24consecutive hours.
26. **Identification** or **ID card** means the card issued to You by us.
27. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment..
    a. **Acute condition** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b. **Chronic condition** is defined as a disease, illness, or injury that has one or more of the following characteristics:— it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires rehabilitation for the patient or for the patient to be specially trained to cope with it—it continues indefinitely—it recurs or is likely to recur.
28. **Inception Date** means the commencement date of the coverage under this Policy as specified in the Policy Schedule
29. **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.
30. **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.
31. **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.
32. **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.
33. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
34. **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.
35. **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.
36. **Medically necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    i. is required for the medical management of the illness or injury suffered by Insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;

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iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

37. **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.
38. **Migration** means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer
39. **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.
40. **Newborn Baby** means baby born during the Policy Period and is aged upto 90 days.
41. **Non- Network** means any hospital, day care centre or other provider that is not part of the network.
42. **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
43. **Policy** means the policy schedule (including endorsements if any), the terms and conditions in this document, any annexure thereto (as amended from time to time) and your statements in the Proposal form.
44. **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 (4.15) below.
45. **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.
46. **Policy Certificate** 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 certificate.
47. **Pre-existing Disease means any condition, ailment, injury or disease:**
    a) That is/are diagnosed by a physician within 48 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 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
48. **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
49. **Post-Hospitalization Medical Expenses m**eans medical expenses incurred immediately after the Insured Person is discharged from the hospital, provided that
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
50. **Pre-Hospitalization Medical Expenses m**eans medical expenses incurred immediately before the Insured Person is Hospitalised, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
51. **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
52. **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

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53. **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.
54. **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.
55. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses**.**
56. **Sum Insured** means the amount shown in the policy schedule which shall be our maximum liability for each Insured Person for any and all benefits claimed for during the policy period and in relation to a Family Floater our maximum liability for any and all claims made by You and all of Your Dependents during the Policy period.
57. **Surgery or Surgical Procedure means** manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner
58. **Unproven/Experimental treatment** means the treatment including drug Experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
59. **Waiting period** refers to the period during which we shall not be liable to make any payment for any claim for treatment. This is not applicable if caused directly due to an accident during the policy period.
60. **List of Critical Illness and their definitions**

63.1 Cancer of Specified Severity

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumours in the presence of HIV infection

63.2 Stroke Resulting In Permanent Symptoms

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

The following are excluded:

a. Transient ischemic attacks (TIA)
b. Traumatic injury of the brain
c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

63.3 Myocardial Infarction(First Heart Attack - of Specified Severity)

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I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris

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

63.4Open Chest CABG

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

II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

63.5 Kidney Failure Requiring Regular Dialysis

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

63.6 Multiple Sclerosis With Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

II. Other causes of neurological damage such as SLE and HIV are excluded

63.7Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:
One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or Human bone marrow using haematopoietic stem cells The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
The following are excluded:

I. Other stem-cell transplants
II. Where only islets of langerhans are transplanted

63.8Permanent Paralysis of Limbs

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

63.9Surgery to Aorta

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

63.10 Primary Pulmonary Hypertension

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

II. The NYHA Classification of Cardiac Impairment are as follows:
   i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present event at rest.

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

63.11 Parkinson's Disease

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

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

Activities of Daily Living:

I. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
II. Dressing: the ability to put on, take-off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
III. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa
IV. Mobility: the ability to move indoors from room to room on level surfaces;
V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
VI. Feeding: the ability to feed oneself once food has been prepared and made available.

Exclusions: Drug induced or toxic causes of Parkinsonism are excluded

63.12 Motor Neuron Disease with Permanent Symptoms

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

3. E X C L US I O N S

a. Waiting Periods:

i. Pre-Existing Diseases – Code – Excl01:

a) Expenses related to the treatment of a Pre-Existing Disease(PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

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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 portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of first 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 : Cataracts, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Fistula in anus, Piles, internal congenital disease, Sinusitis and related disorders.
If these diseases are pre-existing at the time of proposal, the same will be considered under the policy as per exclusion 3.a.i above

iii. 30-day waiting period – Code – Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

b. Exclusions

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

1. **Investigation & Evaluation – Code – Excl04:**
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
2. **Rest Cure, rehabilitation and respite care – code – Excl05:**
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
      ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3. **Obesity/Weight Control: Code – Excl06**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

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1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) Greater than or equal to 40 or
   b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe sleep Apnea
      iv. Uncontrolled Type2 Diabetes

4. **Cosmetic or plastic Surgery:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner. **Code – Excl08**
5. **Hazardous or Adventure sports:** Expenses related to any treatment, necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving. **Code – Excl09**
6. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Excl12**
7. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl13**
8. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. **Code – Excl14**
9. **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less 7.5 dioptres. **Code – Excl15**
10. **Sterility and Infertility: Code – Excl17**: Expenses related to Sterility and infertility. This includes:
    (i) Any type of contraception, sterilization
    (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    (iii) Gestational Surrogacy
    (iv) Reversal of sterilization
11. **Maternity: Code – Excl18:**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
12. Circumcision unless necessary for the treatment of an Illness not otherwise excluded in this Section, or required as a result of Accidental Bodily Injury .
13. Independent personal comfort and convenience items or services which are non-medical in nature and are charged separately unless they form part of the room rent.
14. Durable medical equipment (including but not limited to wheelchairs, crutches, artificial limbs and the like), (namely that equipment used externally from the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose; is generally not useful in the absence of a Illness or Injury and is usable outside of a Hospital) unless required for the treatment of Illness or Accidental Bodily Injury .
15. Any expenses incurred towards hearing aids, eyeglasses or contact lenses.
16. Any travel or transportation costs or expenses.
17. Outpatient prescribed or non-prescribed medical supplies including elastic stockings, bandages, gauze, syringes, diabetic test strips, and similar products; non-prescription drugs and treatments.

18. War, invasion, acts of foreign enemies, hostilities whether war be declared or not, civil war, revolution, insurrection, mutiny, martial law, terrorism or terrorist acts.
19. Ionising radiation or contamination by radioactivity from any nuclear waste or from combustion of nuclear fuel or otherwise; or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof, or asbestosis or any related condition resulting from the existence, production, handling, processing, manufacture, sale, distribution, deposit or use of asbestos, or asbestos products.
20. Sexually transmitted disease or illness
21. Costs incurred on all method of medical treatment except allopathic.
22. Any condition after the point at which it is certified by the attending Doctor to be of such a nature that further medical treatment may serve to stabilise or maintain it but is unlikely to result in a material improvement within a reasonable timeframe.
23. Any congenital external disease.
24. Non medical Expenses incurred during Hospitalisation. The list of such Non medical Expenses is placed at Annexure 1

4. GENERAL CONDITIONS

4.1 Conditions 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.

4.2 Disclosure of Information
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

4.3 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.

4.4 Due care
The Insured Person / persons shall take or procure to be taken all reasonable care and precautions to prevent a claim arising under this Policy and, in the event of a claim arising, to minimise its financial consequences

4.5 Excluded Providers (Code-Excl11)-Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses upto the stage of stabilization are payable but not the complete claim

4.6 Claim Procedure
If You happen to suffer Accidental Bodily Injury or is diagnosed with an Illness which gives rise to or may give rise to a claim, then it is a condition precedent to our liability that You shall immediately:

a. Give us notice of the claim at the earliest irrespective of notice provided to any other insurer for the same illness in case you are holding multiple insurance policies
b. Expeditiously give or arrange for us to be provided with any and all information and documentation in respect of the claim and/or our liability for it that may be requested by the us
c. In case of Cashless admission in Network Hospital, pre-authorisation has to be obtained 72 hours prior to the date of planned admission and within 48 hours of an emergency admission.
d. In case of admission in Non Network Hospital, claim intimation has to be given to us in writing or mail or phone within seven days from the date of hospitalization/injury/death.

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4.6.1 Procedure for Cashless claims:

Obtain our pre-authorisation for any medical treatment in any of our network hospitals. Insured can view or download the updated Hospital Network from the Company's website www.cholainsurance.com. In case of planned admission, pre-authorisation has to be obtained 72 hours prior to the date of admission and within 48 hours of an emergency admission. Pre-authorisation request shall, if we are satisfied as to the validity of the claim, specify:

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

4.6.2 Procedure for submission of Reimbursement Claims

1. Upon Hospitalisation, the insured Person or his/her dependents shall provide us with fully particularised details of the quantum of any claim to be reimbursed and any and all other information and documentation in respect of the claim and/or our liability for it sought by our In-House Claims team at the earliest possible opportunity not exceeding 30 days from date of discharge.
2. We shall be under no obligation to pay or arrange to make payment for any claim until and unless it is satisfied as to the validity and quantum of Your claim.
3. The Insured shall obtain and furnish to the Company all copy of bills, receipts and any other documentation upon which a claim is based. `Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The expenses towards doctors' fees for any additional medical examination required by us, at the time of claim shall be borne by us.
4. We shall only make payment (unless already paid direct to the service provider/hospital) to You or your Nominee.
5. You acknowledge and agree that the payment of any claim by or on behalf of us shall not constitute on the part of us any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by You, it being agreed and recognised by You that we are not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution (including a Network Hospital) whether pre-authorised or not.
6. Following documents are to be submitted for processing of the claim:
   - Claim Form duly filled and signed by patient/You.
   - Original Discharge summary in the hospital letter head with the seal and sign of the doctor with complete details of diagnosis, treatment given, treatment advised etc
   - Original Main bill from the hospital with cost wise break up.
   - Original payment receipt (Receipt should have Serial No)
   - Original investigation reports (such as X Ray, Lab Reports, Scan reports etc) – These are required for supporting the ailment, hence all reports taken prior / at the time or after the hospitalization are required.
   - All pharmacy bills should be accompanied with relevant prescriptions. Bills should contain date and patient name. If pharmacy is charged in the Main Hospital bill, then proper itemized break up of those medicines should be obtained from the hospital.
   - Implant stickers or invoice where ever applicable
   - In case of Road traffic accident (RTA), copy of FIR and/or Medico legal Certificate (MLC) would be required.
   - Proof of identity and residence of the beneficiary for claims exceeding Rs 1 Lakh

4.6.3 Claim Settlement

- 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
- 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.
- 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.

- 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)

4.6.4 TPA

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

4.6.5 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

4.7 Authority to Obtain Records

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

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

4.8 Transfer

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

4.9 Specific and Permanent Exclusions (Applicable for other than Employer-Employee Groups):

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

b. Permanent exclusions may be applied for diseases disclosed by the person to be insured at the time of underwriting with due consent of the proposer or person to be insured, where underwriting policy of the Company does not enable Us to offer the Health Insurance Coverage for the given disease disclosed.

4.10Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sublimits, co-payments ,deductibles as per the policy contract.

4.11 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

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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.

4.12 Possibility of Revision of Terms of the policy including the Premium Rates:
The company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

4.13 **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 such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

4.14 Sum Insured Enhancement
Sum insured can be enhanced only at the time of renewal subject to reported claim status and health condition of the insured. If you decide to increase the sum insured at the time of renewal, subject to our acceptance, then the coverage for the increased sum insured shall be as if a new policy is issued for the additional sum insured. The additional Sum Insured will be available subject to 30 day, 1 year and 4 years waiting periods as per exclusions 3.a.i ,3.a.ii and 3.a.iii above

4.15 Cancellation of cover
i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

Period on Risk	Rate of Premium to be retained
Up to 1 month	25% of annual premium
Up to 3 months	50% of annual premium
Up to 6 months	75% of annual premium
Exceeding 6 months	Full annual premium

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the insured person by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

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

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4.16 Nomination:
The policyholder is required at the inception of the policy 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.

4.17 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.

4.18 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 as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed guidelines on migration, kindly refer the link: www.cholainsurance.com

4.19 Arbitration

a. Any dispute or difference between the Insurer and the Insured Person or the Policyholder will be resolved in accordance with Arbitration & Conciliation Act 1996 or any modification or amendment of it. The arbitration proceedings shall be conducted in the English language.
b. It is agreed as a condition precedent to any right of action or suit on this Policy that a final arbitration award shall be first obtained.
c. If this arbitration clause is held to be invalid in whole or in part, then all disputes shall be referred to the exclusive jurisdiction of Chennai Courts.

4.20 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.

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

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

4.23 Misdescription
This Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact by the insured person(s).

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

4.25 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 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 insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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.

4.26 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.

4.27 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 Your control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Your end and especially if the delay has hindered conducting investigation on time to make proper assessment, to mitigate further loss, if any may not only delay the claim settlement but also may result in claim getting rejected on merits.

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4.28 Disclaimer

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

5. G R I E V A N C E S

Mechanism for Grievance Redressal:-

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

Website : www.cholainsurance.com
Toll free : 1800 208 5544
E-Mail : customercare@cholams.murugappa.com
Fax : 044 -4044 5550
Courier : **Cholamandalam MS General Insurance Company Limited, Customer services,** Head Office **Dare House** 2nd floor, No 2 N.S.C. Bose Road, Chennai 600 001

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at GRO@cholams.murugappa.com

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

If any Grievances / issues on Health insurance related claims pertaining to Senior Citizens, Insured can register the complaint / grievance in 'Senior Citizen Channel' which shall be processed on Fast Track Basis by dedicated personnel.

If Insured Person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management system https://igms.irda.gov.in/

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380014 Tel.: 079-27546150/27546139, Fax: 079-27546142, Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevansoudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru 560078. Tel.: 080-26652048/26652049, Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, Janakvihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462003. Tel.: 0755-2769201/2769202, Fax.: 0755-2769203, Email.: bimalokpal.bhopal@ecoi.co.in

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Odisha	Office of the Insurance Ombudsman, 62, Foresh Partk, Bhubhaneshwar – 750009. Tel.: 0674-2596461/2586455. Fax.: 0674-2596429. Email.: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No.101, 102 & 103, 2nd Floor, Batra Building, Sector 17-D, Chandigarh – 160017. Tel.: 0172-2706196/2706468. Fax.: 0172-2708274, Email.: bimalokpal.chandigarh@ecoi.co.in
Tamilnadu, UT-Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	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
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110002. Tel. 011-23239633/23237532, Fax.011-23230858, Email.: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361-2132204/2132205, Fax.: 0361-2732937, Email.: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam-a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin court", Lane Opp., Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, Hyderabad – 500004. Tel.: 040-65504123/23312122, Fax.: 040-23376599, Email.: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman,JeevanNidhi – II Bldg, Gr. Fllor, Bhawani Singh Marg, Jaipur – 302005. Tel.: 0141-2740363, Email.: Bimalokpal.jaipur@ecoi.co.in
Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cohin Shipyard, M. G. Road, Ernakulam – 682015, Tel.: 0484-2358759/2359338, Fax.: 0484-2359336, Email.: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg, Annexe, 4th Floor, 4, C.R. Avenue, Kolkata – 700072. Tel. 033-22124339/22124340. Fax. 033-22124341, Email.: bimalokpal.kolkata@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	Office of the Insurance Ombudsman, 6th Floor, Jeevanbhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow – 226001. Tel.: 0522-2231330/2231331. Fax.: 0522-2331310. Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevanseva Annexe, S.V. Road, Santacruz (W), Mumbai – 400054. Tel.: 022-26106552/26106960. Fax: 022-26106052. Email: bimalokpal.mumbai@ecoi.co.in

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State of Uttaranchal and the following districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Baudam, 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,	Office of the Insurance Ombudsman, Bhagwansahai Palace, 4th floor, Main Road, Naya Bans, Sector 15, Distt: gautambhuddh Nagar, U.P – 201301. Tel.: 0120-2514250/2514251/2514253. Email.: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 1st Fllor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800006, Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg, 3rd floor, C.T.S. No.s 195 to198, N.C. Kelkar Road, Narayan Peth, Pune-411030 Tel: 020-32341320, Email: bimalokpal.pune@ecoi.co.in

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai – 600 001.
Toll free: 1800 208 5544, T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123; PAN AABCC6633K CIN U66030TN2001PLC047977

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AN N E X U R E 1 *(attached to and forming part of policy wordings)*

List of Non-Medical Expenses excluded in this Policy

LIST I – ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY	
Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICES CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISON CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINLT

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44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/SHORT/HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELTT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES – SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDER LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERYKIT, ORTHOKIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU0DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES

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23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSE
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
LIST III – ITEM THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1	HAIR REMOVAL CREAM
2	DISPOSABLE RAZORS CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD, CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP – COST
8	HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES – DIET CHARGES

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10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOLT SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG