Sections

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Section 1 : Customer Information Sheet

S No	Title	Description	Policy Clause Number
1	Product Name	Approved Brand Name	Chola MS Family Healthline Insurance
2	What am I covered for:	Hospital admission longer than 24 hrs	Section 3 Coverages 3.1.1
		Related medical expenses incurred 60 days prior to date of admission	Section 3 Coverages 3.1.3
		Related medical expenses incurred 90 days from date of discharge	Section 3 Coverages 3.1.2
		Listed day care procedures requiring hospitalization for less than 24 hrs	Section 3 Coverages 3.1.5
		Ambulance Expenses	Section 3 Coverages 3.1.4
		Home Hospitaliation	Section 3 Coverages 3.1.6
		Maternity Expenses	Section 3 Coverages 3.1.7
		Ayurvedic Therapy treatment	Section 3 Coverages 3.1.8
		Out Patient Dental Treatments	Section 3 Coverages 3.2.1
		External Aids - Spectacles, Contact Lenses, Hearing Aid	Section 3 Coverages 3.2.2
		Minor Accompaniment Cash	Section 3 Coverages 3.2.3
		Daily Cash for choosing shared accommodation	Section 3 Coverages 3.2.4
		General Health and Eye Check Up	Section 3 Coverages 3.2.5

3	What are the Major exclusions in the policy:	Circumcision unless necessary for the treatment of an Illness not otherwise excluded in this Section, or required as a result of Accidental Bodily Injury	Section 5 General Exclusion 5.3 – 5.3.1
		Vaccination or inoculation unless forming a part of post-animal bite treatment	Section 5 General Exclusion 5.3 – 5.3.3
		The treatment of obesity (including morbid obesity) and any other weight control programs, services, or supplies	Section 5 General Exclusion 5.3 – 5.3.7
		HIV AIDS and all related medical conditions Refer policy wordings for detailed list of exclusions	Section 5 General Exclusion 5.3 – 5.3.16
4	Waiting period	Initial Waiting period: 30 days for all illness (not applicable on renewal and for accidents)	Section 5 Waiting Period 5.1 – 5.1.1
		Specific Waiting period: - 12 months for listed disease - 24 months for listed disease - Maternity Expenses - OPD Dental - External Aids	 Section 5 Waiting Period 5.1 – 5.1.2 Section 5 Waiting Period 5.1 – 5.1.2 Section 3 Coverages 3.1.7 Section 3 Coverages 3.2.1 Section 3 Coverages 3.2.2
		Pre-existing diseases: covered after 48 months	Section 5 - 5.2
5	Payout basis	Cashless Hospitalisation Reimbursement of covered expenses upto specified limits	Section 6 General condition 6.4.1 Section 6 General condition 6.4.2
6	Cost sharing	In case of a claim, this policy requires you to share the following costs: - Expenses exceeding the following sub-limits - co-payment	 Section 2 : Schedule of Benefits Section 2 : Schedule of Benefits
7	Renewal Conditions	The policy is ordinarily renewable till lifetime, unless on grounds of moral hazard, misrepresentation, fraud or non-cooperation by the Insured.	Section 6 General condition 6.8
		Other terms and conditions of renewal	Section 6 General condition 6.8
8	Renewal Benefits	5% increase in the Insured's annual limit for every claim free year	Section 3 Coverages 3.2.6

9	Cancellation	This policy would be cancelled, and no claim or refund would be due to the Insured if: - Insured/Proposer has not correctly disclosed details about Insured's current and past health status OR - Insured has otherwise encouraged or participated in any fraudulent claims under the policy	Section 6 General condition 6.10
10	Nomination	As per the Health Insurance Regulations, all proposal forms will be provided with nomination facility to the Policyholder to receive money secured by the Policy in the event of death. In case the nominee is a minor, then the Policyholder can appoint the person to receive the money secured by the policy in the event of the Policyholder's death during the minority of the nominee. Policy will contain an acknowledgement of having registered the nomination. Any subsequent cancellation by the Policyholder or change in nomination will be duly acknowledged.	Section 6 General condition 6.11

Note: The information furnished above must be read in conjunction with product brochure and the policy documents. In case of any conflict between the KFD and policy documents, the terms and conditions mentioned in the policy documents shall prevail.

We issue this insurance policy to You and/or Your Family based on the information provided by You / Proposer in the proposal form and premium paid by You/ Proposer. This insurance is subject to the following terms and conditions. This policy covers Your Family 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.**

Section 2 : SCHEDULE OF BENEFITS

Benefits in the table below should be read in conjunction with Section 3 Coverages and Section 4 Definitions

S No	Benefits / Plan	Standard	Superior	Advanced
1	Sum Insured on Floater basis (in Lakhs)	2/3/4/5	3/4/6/8/10/12/15	4/6/8/10/12/15
2	Hospitalization Expenses	Covered	Covered	Covered

3	Entry Age	3 months to 65 Years	3 months to 65 Years	3 months to 65 Years
4	Pre Hospitalization Expenses	60 days	60 days	60 days
5	Post Hospitalization Expenses	90 days	90 days	90 days
6	Emergency Ambulance	Rs.1000 per insured per policy year	Rs.2000 per insured per policy year	Rs.3000 per insured per Policy year
7	Day Care Procedures / Treatment Expenses	Covered	Covered	Covered
8	Room, Boarding & Nursing Expenses	AC Single Room upto Rs.3000 per day	SI – Rs.3&4 Lakhs – AC Single Room upto Rs.3000 per day SI – 6/8/10/12/15 Lakhs - Max 1% of the Sum Insured	SI – Rs.4 Lakhs – AC Single Room upto Rs.3000 per day SI – 6/8/10/12/15 Lakhs - Max 1% of the Sum Insured
9	Home Hospitalization	Cover Not Applicable	Upto 15% of the SI, Max Rs.70,000	Upto 25% of the SI, Max Rs.1 Lakh
10	Maternity Expenses (Waiting period 5 years)	Cover Not Applicable	Normal – Rs.15,000 Caesarean– Rs.25,000	Normal – Rs.25,000 Caesarean–Rs.40,000
11	Ayurvedic Therapy Treatments (20% Co-payment)	Cover Not Applicable	Cover Not Applicable	Upto 7.5% of SI – Specific treatments only
12	OPD Dental (Waiting Period 3 years) – 30% Co-payment	Cover Not Applicable	Cover Not Applicable	1% of SI, Max Rs.5,000
13	External aids (Specs, Contact Lens, Hearing aids) – (Waiting period 3 years) – 30% Co-payment	Cover Not Applicable	Cover Not Applicable	1% of SI, Max Rs.5,000 - once in a block of 2 years
14	Minor Accompaniment Daily Cash	Cover Not Applicable	Rs.250/ day for max 7 days with 1 day deductible	Rs.250/ day for max 14 days with 1 day deductible
15	Daily Cash for choosing shared	Rs.250/ day for max 7 days with 1 day deductible	Rs.500/ day for max 7 days with 1 day deductible	Rs.500/ day for max 14 days with 1 day deductible

16	General Health check-up & eye examination	0.5% of SI once after every two continuous claim free renewals, excluding the year in which the benefit is claimed	0.75% of SI once after every two continuous claim free renewals, excluding the year in which the benefit is claimed	1.0% of SI once after every two continuous claim free renewals, excluding the year in which the benefit is claimed
17	Sublimits Against Diseases	Cataract - 7.5% of SI, max Rs.20000 per eye Hernia or Hydrocele -10% of SI, max Rs.30000 Fistula in Anus, Anal Fissure, Piles -10% of SI, max Rs.30000 Sinusitis -10% of SI, max Rs.30000 Tonsilitis or Adenoids -15% of SI, max Rs.40000	Cataract - 7.5% of SI, max Rs.20000 per eye	NIL
18	Cumulative bonus	5% of Sum Insured every claim free year subject to maximum of 50% of Sum Insured	5% of Sum Insured every claim free year subject to maximum of 50% of Sum Insured	5% of Sum Insured every claim free year subject to maximum of 50% of Sum Insured
19	Reduction in Cumulative Bonus	5% of Sum Insured	5% of Sum Insured	5% of Sum Insured

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

For details on specific benefits refer to Coverage parts (Section 3) of policy Wordings.

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

Insured has the option to avail 10% co-payment or all claims under the policy. By opting this co-payment, Insured gets a discount at the premium.

The 10% co-payment and waiver mentioned above will not be applicable in the case of Sl Nos 11, 12 & 13 in table above for which the co-pay is as specified above.

Above age of 70 yrs an additional co-pay of 20% shall apply in the event of claims over and above other policy conditions.

Section 3 : C O V E R A G E S

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

3.1 Benefits forming part of Sum Insured opted

3.1.1 Hospitalization Expenses

If the Insured is diagnosed with an Illness or suffers Accidental Bodily Injury which necessitates his Hospitalisation, the Insurer will reimburse the Insured Person's consequent hospitalisation expenses upto limits mentioned in the policy schedule for:

a) Room and boarding

b) Doctors fees

c) Intensive Care Unit

d) Nursing expenses

e) Surgical fees, operating theatre, anesthesia and oxygen and their administration

f) Physical therapy expenses

g) Drugs and medicines consumed on the premises

h) Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, diagnostic tests)

i) Cost of Dressing, ordinary splints and plaster casts

j) Costs of prosthetic devices if implanted during a surgical procedure

k) Organ transplantation including the treatment costs of the donor but excluding the costs of the organ

3.1.2 Post-hospitalisation Expenses

If the Insurer accepts a claim under a) above and, immediately following the Insured Person's discharge, he requires further medical treatment directly related to the same condition for which the Insured Person was Hospitalised, the Insurer will reimburse the Insured Person's Post-hospitalisation Expenses for upto 90 days following his discharge.

3.1.3 Pre-hospitalisation Expenses

If the Insured Person is diagnosed with an Illness which results in his Hospitalisation and for which the Insurer accepts a claim under a) above, the Insurer will reimburse the Insured Person's Pre-hospitalisation Expenses for up to 60 days (applicable after 30 days waiting period) prior to hospitalisation as long as the 60 day commences and ends within the Policy Period

3.1.4 Emergency Ambulance

The Insurer will also pay for Emergency ambulance road transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be rendered. Coverage is only provided in the event of an Emergency upto the limits mentioned in the schedule of benefits.

3.1.5 Day Care 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

3.1.6 Home Hospitalisation

The Medical Expenses incurred by an Insured Person for medical treatment taken at his/her home which would otherwise have required Hospitalisation

because, on the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or a Hospital bed was unavailable, and provided that:

a) The condition for which the medical treatment is required continues for at least 2 days, in which case the Policy pays reasonable cost of any necessary medical treatment for the entire period

b) Pre-hospitalisation expenses for up to 60 days in accordance with Section 3.1.3 will be covered under this benefit. Post hospitalisation expenses will not be covered under this benefit.

c) 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. Psychiatric or Psychosomatic Disorders of all kinds,
9. Pyrexia of unknown Origin.

Cashless facility will not be available for such a claim

3.1.7 Maternity Expenses (with 5 year waiting period)

Five consecutive renewals without break, under Superior and Advanced plan of this product shall entitle the insured, from the sixth year onwards, upto limits mentioned in the schedule, to medical expenses for delivery (including caesarean section) while Hospitalised or the lawful medical termination of pregnancy during the policy period excluding elective termination without threat to mother or child's life, limited to 2 deliveries or terminations or either one of each during the lifetime of the Insured. This will include ectopic

pregnancy, pre-natal and post-natal expenses per delivery or termination and medically necessary treatment of the new born baby within the policy period provided that:

a. Maximum liability per delivery or termination shall be limited to the amount specified in the Schedule of Benefits

b. Pre- and post-hospitalisation expenses are not covered under this benefit.

c. The Insured Person must have been covered by this policy for the period of time specified in the Schedule of benefits

3.1.8 Ayurvedic Therapy treatment

The insured under Advanced plan of this product is entitled for cost of (non cosmetic) Ayurvedic treatment, restricted to 80% of the actual cost and subject to the maximum limit as mentioned in the benefit schedule and with prior approval from the Insurer, with mandatory 24 hour hospitalization/ residential inpatient with government registered hospital. This is applicable only in case of diseases as per Annexure 1 attached.

The 10% co-payment clause as mentioned in Section 3 is not applicable for this benefit.

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

3.2 Additional Benefits over the Sum Insured

3.2.1 Out Patient Dental Treatments (with 3 year waiting period)

Three consecutive renewals without break, shall entitle the Insured under Advanced plan of this product for 70% of the actual costs of necessary dental treatment from the fourth policy year taken from a dentist provided that:

a. Maximum liability shall be limited to the amount specified in the Schedule of Benefits, and

b. The insurer will pay towards X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same,

c. The policy excludes dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics surgery,

orthognathic surgery, jaw alignment or treatment for the tempero-mandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the tempero-mandibular (jaw) unless necessitated by an acute traumatic injury, burns or cancer.

This benefit will commence only after 3 year waiting period. The 10% co-payment clause as mentioned in Section 3 is not applicable for this benefit.

The benefit under this section becomes payable only on commencement of the 4th policy year.

3.2.2 External Aids - Spectacles, Contact Lenses, Hearing Aid (with 3 years waiting period)

Three consecutive renewals without break, shall entitle the Insured under Advanced plan of this product for 70 % of the actual cost of either of the following.

a. One pair of spectacles or contact lenses, OR

b. A hearing aid, excluding batteries.

From the fourth year, this benefit can be availed once in a block of two years on continuous renewals with out a break with the insurer, provided that:

a. If the costs claimed are incurred as Outpatient Treatment expenses then these items must be prescribed by a EYE/ENT specialised Medical Practitioner, and

b. Insurers maximum liability shall be limited to the amount mentioned in the Schedule of Benefits

The 10% co-payment clause as mentioned in Section 3 is not applicable for this benefit.

The benefit under this section becomes payable only on commencement of the 4th policy year.

3.2.3 Minor Accompaniment Cash

If the Insured Person Hospitalised is a child Aged 12 years or less, We will pay a daily cash amount limited to the amount mentioned in the Schedule of Benefits for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours, provided that:

a. Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and

b. We have accepted an inpatient Hospitalisation claim under Section 3.1.1

3.2.4 Daily Cash for choosing shared accommodation

A daily cash amount will be payable per day if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours, provided that:

a. Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and

b. This benefit shall not apply to time spent by the Insured Person in an intensive care unit, and

c. We have accepted an inpatient Hospitalisation claim under Section 3.1.1

3.2.5 General Health and Eye Check Up

If no claim has been made by the insured persons in respect of any benefits and the insured has renewed the policy with us for the two continuous claim free years,, we will pay upto the percentage (mentioned in the Schedule of Benefits) of the Sum Insured (excluding the Claim free Bonus if any) towards the cost of a medical check-up for those Insured persons

who were insured for the number of previous Policy years mentioned in the Schedule.

In respect of this benefit, claim free year means a policy year in which no claim has been admissible by the company from the insured. Any unutilized limit under a particular policy shall lapse once the policy expires.

3.2.6 Cumulative Bonus

If the insured has not made a claim in a policy year and has renewed the policy with us without a break, we will increase your Sum Insured under each subsequent policy by a percentage of the expiring policy Sum Insured as mentioned in the schedule of benefits. The maximum cumulative bonus shall at no time exceed 50% of the policy Sum Insured. Cumulative bonus will be applicable only if none of the family members have made a claim under the previous policy year.

3.2.7 Reduction in Cumulative Bonus

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

Cumulative bonus earned will not be reduced if a cailm is made under benefit 3.2.1, 3.2.2 & 3.2.5

Section 4 : 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 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. **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 it 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** shall mean a policy term or condition upon which our liability under the policy is valid.

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

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

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

10. **Contribution** means essentially the right of an insurer to call upon other insurers, liable to the same insured to share the cost of an indemnity claim on a ratable proportion of the Sum Insured

    This clause shall not apply to any Benefit offered on fixed benefit basis.

11. **Co-Payment** is a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specific percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured

12. **Cumulative Bonus** shall mean any increase in the sum assured granted by us without an associated increase in premium

13. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical set up within 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 criteria 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.

14. **Day care Procedure/ 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.

15. **Dental treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

16. **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 and parents

17. **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

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

19. **Disclosure to Information norm :** The 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.

20. **Domiciliary/ home hospitalization** 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.

21. **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.

22. **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

23. **Excluded Hospital** means any hospital which we might discourage You to take treatment of any sickness or illness, due to fraud or moral hazard or misrepresentation indulged by the hospital

24. **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

25. **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.

26. **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:

    a. Has qualified nursing staff under its employment round the clock;

    b. Has at least 10 inpatient beds in towns having a population of less than 10,00,000 and at least 15 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 make these accessible to the Insurance Company's authorized personnel.

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

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

29. **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:—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 your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

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

31. **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

32. **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

33. **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

34. **Maternity Expenses** shall include

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization)

b) Expenses towards lawful medical termination of pregnancy during the policy period

35. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

36. **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.

37. **Medical Practitioner/Doctor** means 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 the scope and jurisdiction of license.

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

38. **Medically necessary** 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 You;

    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.

39. **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.

40. **Network Provider/ Hospital** mean Hospitals or health care providers enlisted by the insurer to provide medical services to an insured on payment by a cashless facility. The list is available with the insurer and subject to amendment from time to time.

41. **Newborn Baby** means those babies born to you and your spouse during the Policy Period Aged between 1 day and 90 days, both days inclusive.

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

43. **Notification of claim** is the process of notifying a claim to the insurer by specifying the timelines as well as the address / telephone number to which it should be notified

44. **OPD treatment** is 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 Medical Practitioner. The Insured is not admitted as a day care or in-patient.

45. **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.

46. **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 Section 6 - General Condition 6.10 below.

47. **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.

48. **Pre-Existing Diseases** means any condition, ailment or injury or related conditions for which the insured had signs or symptoms and/or were diagnosed and/ or received medical advice/treatment, within 48 months prior to inception of his / her first policy issued by the insurer.

49. **Portability** means transfer by an individual health insurance policy holder (including family cover) to the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another insurer.

50. **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

51. **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.

52. **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

53. **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

54. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

55. **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.

56. **Renewal** defines 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 all waiting periods.

57. **Room Rent** shall mean the amount charged by a hospital for the occupying of a bed on per day (24 hours) basis and shall include associated medical expenses.

58. **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.

59. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

60. **Sum Insured** means the amount shown in the policy schedule which shall be our maximum liability for any and all claims made by you and all of your dependents during the policy period.

61. **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

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

63. **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.

Section 5 : EXCLUSIONS

5.1. **Waiting Periods**

5.1.1. A waiting period of 30 days will apply to all claims from the commencement date of the policy except in case of injuries caused by accidents. This exclusion does not apply for subsequent renewals with the Company without a break

5.1.2. Following diseases are excluded during the first and Second year of inception of policy with the Insurer

Illnesses excluded for One year	Illnesses excluded for Two years
Cataract, Benign Prostratic Hypertropy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Fistula, Piles, Sinusitis & related disorders	Spondilitis, Spondilosis, Knee / Hip joint replacement, Internal congenital diseases , Osteoarthritis of any joint, Calculus diseases of gall bladder and urogenital, Gastric & duodenal ulcers, Internal Tumours, cysts, nodules, polyps including breast lumps (each of any kind unless malignant), Gout & Rheumatism, ENT disorders & Surgery, Surgery of genito urinary system, Surgery for prolapsed inter vertebral disk, Surgery of varicose veins & varicose ulcers, Surgery on tonsils

If these diseases are pre-existing at the time of proposal, the same will be considered under the policy as per exclusion 5.2 below.

Waiting period of 30 days, 1 year and 2 Years will not be applicable if hospitalisation is caused directly due to an accident during policy period.

5.2. **Pre-Existing Disease (PED)**:

Benefits will not be available for any pre-existing condition(s) as defined in the policy, until 48 consecutive months of continuous coverage have elapsed, since inception of the first policy with insurer.

5.3. **General Exclusion**

5.3.1. Circumcision unless necessary for the treatment of an Illness not otherwise excluded in this Section, or required as a result of Accidental Bodily Injury.

5.3.2. Tubectomy, Vasectomy, sex change or treatment, which result from, or is in any way related to sex change. Hormone replacement therapy.

5.3.3. Vaccination, inoculation, cosmetic treatments (including any complications arising out of or howsoever attributable to any cosmetic treatments or the replacement of an existing breast implant) unless necessitated by an acute traumatic injury, burns or cancer, aesthetic treatments, experimental, investigational or unproven procedures or treatments, devices and pharmacological regimens of any description. The exclusion on vaccination does not include post-bite treatment. Exclusion on cosmetic surgery is not applicable where medically required as part of treatment for cancer, accidents and burns.

5.3.4. Vitamins and tonics unless forming a necessary part of the treatment for Illness as certified by the attending Doctor.

5.3.5. Any dental treatment or surgery of a corrective, cosmetic or aesthetic nature unless it requires Hospitalisation; is carried out under general anaesthesia and is necessitated by Illness or Accidental Bodily Injury except to the extent of coverage provided under Section 3.2.1.

5.3.6. Independent personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies which are charged separately unless they form part of room rent.

5.3.7. The treatment of obesity (including morbid obesity) and any other weight control programs, services, or supplies.

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

5.3.9. Diagnostic, X-ray or laboratory examination not incidental to or inconsistent with the diagnosis and treatment of the Illness or Injury for which the

Insured Person was hospitalised.

5.3.10. The Insured Person's participation in any hazardous activities, including but not limited to scuba diving, motor-racing, parachuting, hang-gliding, rock or mountain climbing, as a member of the armed forces, the paramilitary, the security forces, the fire or ambulance services, lifeboat service, police force and the like whether part time or full time, voluntary or paid.

5.3.11. Charges incurred in connection with the provision or fitting of hearing aids, eyeglasses or contact lenses except to the extent of coverage provided under Section 3.2.2.

5.3.12. Any travel or transportation costs or expenses.

5.3.13. The use, misuse, or abuse of alcohol, banned substances or narcotic drugs (whether prescribed or not).

5.3.14. All drugs, treatments and medical supplies including elastic stockings, bandages, gauze, syringes, diabetic test strips, and similar products not supported by a prescription.

5.3.15. Invitro fertilisation (IVF), gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation; voluntary medical termination of pregnancy; any treatment related to infertility or sterilisation.

5.3.16. HIV AIDS and all related medical conditions.

5.3.17. Costs incurred on all medical treatments other than Allopathic Treatments. Ayuvedic expenses covered to the extent of coverage provided under Section 3.1.8.

5.3.18. 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.

5.3.19. Pregnancy(other than ectopic pregnancy), childbirth and their consequences, including changes in chronic conditions as a result of pregnancy except to the extent of coverage provided under Section 3.1.7.

5.3.20. Any external congenital diseases, defects or anomalies, genetic disorders; stem cell implantation or surgery.

5.3.21. War, invasion, acts of foreign enemies, hostilities whether war be declared or not, civil war, revolution, insurrection, mutiny, martial law, terrorism or terrorist acts.

5.3.22. 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.

5.3.23. Treatment taken in excluded hospitals as updated in our website cholainsurance.com from time to time

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

Section 6 : GENERAL CONDITIONS

6.1 Observance of Terms & Conditions

It is a condition precedent to our liability that the insured person shall comply in all respects with the terms and conditions of this Policy in so far as they require anything to be done or complied with by You or Your dependent.

6.2 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

6.3 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.

6.4 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

6.4.1 Procedure for Cashless claims:

Obtain our pre-authorisation for any medical treatment in any of our network hospitals. 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.

6.4.2 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. You shall expeditiously provide us with or arrange for us to be provided with any and all information or documentation, in respect of the Illness, the claim or our liability that may be requested. 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

- Upon acceptance of the offer of claim settlement by the Insured, the claim amount will be settled by the Company within 7 days from the date of acceptance of the offer by the Insured. In case of delay in the payment, the Company shall be liable to pay interest at the rate stipulated by IRDA from time to time.

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

The documents should be sent to or such other address as may be notified to the Insured:

Cholamandalam MS General Insurance Company Limited
Chola MS HELP – Health Claims Department
No. 163, Hari Nivas Towers, 2nd Floor, Thambu Chetty Street
Parry's Corner, Chennai - 600001
Customer Care Toll Free No: 1800-200-5544

6.5 Authority to Obtain Records

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

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

6.6 Transfer

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

6.7 Free Look Period

You shall be allowed a period of 15 days from the date of receipt of this policy to review the terms and conditions of the policy and to return the same if not acceptable.

The Insured can return the policy within 15 days of its receipt if he/she is not satisfied with its coverage or terms and conditions. In such a case the policy will be cancelled from date of cancellation request received at Insurer's office provided no claim is reported and considered. Refund of premium would be after retaining charges towards medical tests, stamp duty charges and pro-rata premium from the risk start date till date of cancellation.

6.8 Renewal of Policy

a. We agree to renew your policy except on grounds of moral hazard, misrepresentation, fraud or non-cooperation by the Insured.

b. This policy can be renewed for a period of 12 months subject to payment of premium prior to expiry of the policy and not later than 30 days grace period posts the expiry of the policy. We condone the delay and renew the policy with continuity benefits.

c. The claims if any occurring during the period of break in insurance shall not be payable under the renewed policy

d. 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, subect 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 days, 1 year, 2 years and 4 years waiting periods as per exclusions 5.1 and 5.2 above.

e. The Company reserve its rights to revise the premium from time to time subject to approval of Authority.

f. In case the policy was purchased through any bank or such Institution selling insurance on our behalf the policy can be renewed through the same channel or directly in case the said channel is discontinued at the time of renewal. Insured shall not stand to lose any benefit in case of such direct renewals for which otherwise the Insured is entitled to.

g. When an insured Person is added to this Policy either by way of endorsement or at the time of renewal the pre-existing disease clause, exclusion and waiting periods will be applicable to that insured considering such policy period as the first policy with us.

h. This product may be withdrawn from the market by informing the Authority giving details of the product and the reasons for withdrawal. We will intimate the Insured person in writing about such withdrawal atleast 30 days prior to the renewal date. The Insured person will have the option to purchase another policy with similar covers if available with the company. This will be subject to portability conditions laid down by IRDA.

i. Any revision or modifications in a policy subject to the approval from the Authority shall be notified to each policy holder atleast three months prior to the date when such revision or modifications comes into effect. The notice shall set out the reason for such revision or modifications.

j. The policy is renewable on payment of renewal premium. Above 70 years renewal of the policy will be on condition that co-payment of 20% shall be applicable in the event of all claims over and above other policy conditions

6.9 Portability:

On renewal from any other Indian insurer's Individual / Family floater indemnity health insurance policy with similar type of cover with same Sum insured, Continuation of benefits would be ensured for the following.

a. **Cumulative Bonus :** Subject to benefits Section 3.2.6 and Section 6.8 above

b. **30 days Waiting Period:** A waiting period of 30 days would be considered to have been served if You were insured continuously and without interruption for at least 1 year under another Indian insurer's individual health / Family Health insurance policy for the reimbursement of medical costs for inpatient treatment in a hospital.

c. **1 Yr waiting period** on specific diseases would be considered to have been served if You were insured continuously and without interruption for 1 year under another Indian insurer's individual health / Family Health insurance policy for the reimbursement of medical costs for inpatient treatment in a hospital.

d. **2 Yrs waiting period** on specific diseases would be considered to have been served if You were insured continuously and without interruption for at least 2 years under another Indian insurer's individual health / Family Health insurance policy for the reimbursement of medical costs for inpatient treatment in a hospital. In case you insured for 1 year in the previous policy, above specific diseases would be covered after completion of 1 year of Insurance with us.

e. **Pre-Existing diseases** will be covered in the policy if You were insured continuously and without interruption for at least 4 years under another Indian insurer's individual health / Family Health insurance policy for the reimbursement of medical costs for inpatient treatment in a hospital.

In case of a difference in Sum insured between old policy and new policy, it would be treated as in Section 6.8- d) above.

6.10 Cancellation of cover

This policy may be cancelled by us on account of misrepresentation, fraud, and non-disclosure of material facts or non cooperation of the insured by giving 15 days written notice delivered to, or mailed to the Insured persons' last address as shown in the records. On such cancellation by us, the insured person shall be entitled to refund of pro-rata premium for the unexpired portion of the policy on the date of cancellation.

The insured person may also cancel the policy at any time in which event, the company shall be entitled to retain premium at Short Period Scale for the expired portion on the date of cancellation. Any excess premium available with us after adjustment at Short Period Scale as provided herein

below shall be refunded to the Insured except for those Insured Person(s) for whom a claim has been paid or is payable in the current policy.

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

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.

6.11 Nomination:

The Insured person is entitled to nominate the person/ persons to whom the money secured by the Policy shall be paid in the event of his death as per the provisions of S.39 of the Insurance Act, 1938. In case the nominee is a minor, the Policyholder can appoint a person who will receive the money secured by the policy in the event of the Policyholder's death during the minority of the nominee.

The details of nomination provided by the Insured will be acknowledged by the Company in the Policy issued by the Company. The Policyholder is entitled to cancel or withdraw the nomination at any time and the Company upon request shall make the necessary endorsement in the Policy

6.12 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.

6.13 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 and the venue will be in Chennai.

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.

6.14 Fraud

If You and or Your dependent shall:

a. Make or advance any claim knowing the same to be false or fraudulent in amount or otherwise, and/or

b. Permit another to use his ID Card or use another's ID Card

c. Do/ omit to act in manner abetting fraud against Us,

this Policy shall be null and void ab inito in relation to that Insured Person. All claims or payments due shall be forfeited and all payments made by us shall be repaid in full by the policyholder/s who shall be jointly and severally liable for the same.

6.15 Subrogation

The Policyholder:

a. Shall do or concur in doing or permit to be done everything necessary for the purpose of enforcing any civil or criminal rights and remedies or obtaining relief or indemnity from other parties to which the Insurer shall be or would become entitled or subrogated upon the Insurer paying for any claim under this Policy, whether before or after indemnification;

b. Shall not do or cause to be done anything that may cause any prejudice to the Insurer's right of subrogation;

c. Agrees that any recoveries made shall first be applied in making good

any sums paid out by or on behalf of the Insurer for the claim and the costs of recovery.

This clause is not applicable for benefit sections of the policy.

6.16 Governing Law

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

6.17 Entire Contract

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

6.18 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).

6.19 Contribution

If the insured is covered under two or more policies during a period from one or more insurers to indemnify treatment costs and have declared details of the other poicies in our proposal for insurance, we shall call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum insured.

This clause is not applicable for fixed benefit sections of the policy.

6.20 Territorial Limits

The Insurer's liability to make any payment towards illness or accidental injury shall be to make payment within India and in Indian Rupees only for medical services or procedures rendered in or undertaken within India.

6.21 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.

6.22 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.

6.23 Automatic Termination

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

- Upon the demise of the covered person, in which case we will refund premium calculated on pro-rata basis for the unexpired period subject there being no claim under the policy.
- Upon exhaustion of the sum insured. However this will not affect the renewal for the subsequent period.

6.24 Cost of pre-insurance health checkup

Based on acceptance of the proposal and issuance of policy, we would reimburse to the insured 50% 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.

6.25 Two Policy Period

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal / due date of premium of this health policy if not received ealier.

6.26 Any one illness / relapse period :

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

Section 7 : G R I E V A N C E S

Mechanism for Grievance Redressal:-

As an esteemed customer of our Company, You can contact us to register complaint/ grievance, if any, including servicing of policy, claims etc. with regard to the insurance policy issued to You. The contact details of our office are given below for Your reference.

A separate Channel will be established to address the issues relating to **Senior Citizen's** Health Insurance related claims and grievances and will be intimated to the policy holders

Cholamandalam MS General Insurance Company Limited
Customer services
Address: H.O: Dare House 2nd floor, No 2 N.S.C. Bose Road, Chennai 600 001.
Toll free: 1800 200 5544
SMS: "CHOLA" to 56677* (premium SMS charges apply)
E-MAIL: customercare@cholams.murugappa.com
WEBSITE: www.cholainsurance.com

If You have not received any reply from us within 3 days from the date of the lodgment of complaint or if You are not satisfied with the reply of the Company, You can also contact the nearest Insurance Ombudsman, whose addresses are mentioned below:

Sl. No	Office of the Ombudsman	Name of the Ombudsman and Contact Details	Areas of Jurisdiction
1	AHMEDABAD	Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, 5, Navyug Colony, Ashram Road, AHMEDABAD - 380 014 Ph(O) 079-27546150, 27546139 Fax: 079-27546142 E-mail: insombahd@rediffmail.com	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
2	BHOPAL	Office of the Insurance Ombudsman 1st Floor, 117, Zone-II, Above D.M. Motors Pvt. Ltd. Maharana Pratap Nagar, Chhattisgarh BHOPAL - 462 011 Ph(O): 0755-2769200, 2769202, 2769201,Fax: 0755-2769203 E-mail: bimalokpalbhopal@airtel-broadband.in	Madhya Pradesh & Chhattisgarh
3	BHUBANESWAR	Office of the Insurance Ombudsman 62 Forest Park BHUBANESHWAR - 751009 Ph (0): 0674-2535220,2533798 Fax: 0674-2531607 E-mail: ioobbsr@dataone.in	Orissa
4	CHANDIGARH	Office of the Insurance Ombudsman S.C.O. No. 101,102 & 103, 2nd Floor, Batra Building, Sector 17-D, CHANDIGARH - 160017 (0) 0172-2706196, 2705861 EPBX: 0172-2706468 Fax: 0172-2708274 E-mail: ombchd@yahoo.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh

5	CHENNAI	Office of the Insurance Ombudsman Fatima Akhtar Court, 4th Flr., No 453(old no 312), Anna Salai, Teynampet, CHENNAI -600 018 (0) 044-24333678, 24333668 Fax: 044-24333664 E-mail: insombud@md4.vsnl.net.in	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
6	DELHI	Office of the Insurance Ombudsman 2/2 A, 1st Floor, Universal Insurance Bldg., Asaf Ali Road,,NEW DELHI - 110 002 (0) 011-23239611, 23237539, 23237532 Fax: 011-23230858 E-mail : iobdelraj@rediffmail.com	Delhi & Rajasthan
7	GUWAHATI	Office of the Insurance Ombudsman Aquarius, Bhaskar Nagar, R.G. Baruah Rd., GUWAHATI - 781 021 (0) 0361-2413525, EPBX: 0361-2415430 Arunachal Pradesh, Fax: 0361-2414051 E-mail: omb_ghy@sify.com	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
8	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. (0) 040-23325325, 23312122, 65504123, Fax: 040-23376599 E-mail: hyd2_insombud@sanchar-net.in	Andhra Pradesh Karnataka and UT of Yanam - a part of the UT of Pondicherry

9	KOCHI	Office of the Insurance Ombudsman 2nd Fir., CC 27/ 2603 Pulinat Building Opp. Cochin Shipyard, M.G. Road, ERNAKULAM - 682 015 (0) 0484-2358734, 2359338, 2358759 Fax: 0484-2359336 E-mail: ombudsmankochi@yahoo.co.in	Kerala, UT of (a) Lakshad-weep, (b) Mahe - a Part of UT of Pondicherry
10	KOLKATA	Office of the Insurance Ombudsman North British Bldg. 29, N. S. Road, 3rd Fir., KOLKATA -700 001. (0) 033-22134869, 22134867, 22134866 Fax: 033-22134868 E-mail : iombkol@vsnl.net	West Bengal, Bihar, Jharkhand and UT of Andaman & Nicobar Islands, Sikkim
11	LUCKNOW	Office of the Insurance Ombudsman Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Rd., Hazartganj, LUCKNOW - 226 001 (0) 0522-2201188, 2231330, 2231331 Fax: 0522-2231310 E-mail: ioblko@sancharnet.in	Uttar Pradesh and Uttaranchal
12	MUMBAI	Office of the Insurance Ombudsman 3rd Flr., Jeevan Seva Annexe, S.v. Road, Santa Cruz (W) MUMBAI - 400 054 022-26106928, 26106360 EPBX: 022-6106889 Fax: 022-26106052 Email: ombudsman@vsnl.net	Maharashtra, Goa

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

List of Ayurvedic ailments treatments/Cures which are eligible for payment under the scope of this policy

Sl No	Ayurvedic Ailments Treatment/Cures Available
1	Ayurveda Treatments for Myalgic Encephalomyelitis (ME) / Chronic Fatigue Syndrome (CFS)
2	Ayurveda Treatments for Vascular Disorders and Cardiac Conditions
3	Ayurveda Treatment for MS or Multiple Sclerosis
4	Ayurveda Treatment for Body Paralysis and Hemiplegia
5	Ayurvedic Treatment for Diabetes
6	Ayurvedic Treatment for Blood Pressure (BP)
7	Ayurvedic Treatment for High Cholestrol
8	Ayurvedic Treatment for Slip Disc & Chronic Low Back Pain
9	Ayurvedic Treatment for Cancer
10	Ayurvedic treatment for breast cancer, cancer of uterus, throat cancer
11	Ayurvedic Treatment for E.N.T. Diseases
12	Ayurvedic treatment for epilepsy
13	Ayurvedic treatment for Facial Paralysis
14	Ayurvedic treatment for gastric and liver problems
15	Ayurvedic treatment for eye disorders
16	Ayurvedic treatment for cerebral palsy
17	Ayurvedic treatment for Alzheimer's disease
18	Ayurvedic treatment for Kidney and bladder stones
19	Ayurvedic treatment for diabetes and cholesterol
20	Ayurvedic treatment for Polio
21	Ayurveda Treatment for Neurological Complaints
22	Ayurveda Treatment for Neuralgia
23	Osteoarthritis
24	Rheumatoid arthritis
25	Cervical & Lumbar spondylosis.
26	Myalgic
27	Psoriasis
28	Eczema
29	Paralysis, [Hemiplegia, Paraplegia]
30	Degenerative diseases of spine

Sl No	Ayurvedic Ailments Treatment/Cures Available
31	Sciatica
32	Migraine
33	Acid peptic disorders
34	Piles
35	Fistula
36	Constipation, loss of appetite
37	Asthma, esonophilia
38	Chronic bronchitis
39	Sinusitis
40	Metabolic disorders like DM, HT, Liver and kidney dys function

AN N E X U R E 2 *(attached to and forming part of policy wordings)*
List of Non-Medical Expenses excluded in this Policy

S.No	NAME OF THE NON MEDICAL ITEM	Admissibility
TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	ANNE FRENCH CHARGES	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BOTTLE	Not Payable
8	BRUSH	Not Payable
9	COSY TOWEL	Not Payable
10	HAND WASH	Not Payable
11	MOISTURISER PASTE BRUSH	Not Payable
12	POWDER	Not Payable
13	RAZOR	Payable
14	TOWEL	Not Payable
15	SHOE COVER	Not Payable
16	BEAUTY SERVICES	Not Payable
17	BELTS/ BRACES	Payable for cases who have under-gone surgery of thoracic or lumbar spine.
18	BUDS	Not Payable
19	BARBER CHARGES	Not Payable
20	CAPS	Not Payable
21	COLD PACK/HOT PACK	Not Payable
22	CARRY BAGS	Not Payable
23	CRADLE CHARGES	Not Payable
24	COMB	Not Payable
25	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
26	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
27	EYE PAD	Not Payable
28	EYE SHEILD	Not Payable

29	EMAIL / INTERNET CHARGES	Not Payable
30	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
31	FOOT COVER	Not Payable
32	GOWN	Not Payable
33	LEGGINGS	Payable for bariatric and varicose vein surgery where surgery itself is payable.
34	LAUNDRY CHARGES	Not Payable
35	MINERAL WATER	Not Payable
36	OIL CHARGES	Not Payable
37	SANITARY PAD	Not Payable
38	SLIPPERS	Not Payable
39	TELEPHONE CHARGES	Not Payable
40	TISSUE PAPER	Not Payable
41	TOOTH PASTE	Not Payable
42	TOOTH BRUSH	Not Payable
43	GUEST SERVICES	Not Payable
44	BED PAN	Not Payable
45	BED UNDER PAD CHARGES	Not Payable
46	CAMERA COVER	Not Payable
47	CARE FREE	Not Payable
48	CLINIPLAST	Not Payable
49	CREPE BANDAGE	Not Payable
50	CURAPORE	Not Payable
51	DIAPER OF ANY TYPE	Not Payable
52	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
53	EYELET COLLAR	Not Payable
54	FACE MASK	Not Payable
55	FLEXI MASK	Not Payable
56	GAUSE SOFT	Not Payable
57	GAUZE	Not Payable
58	HAND HOLDER	Not Payable
59	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
60	LACTOGEN/ INFANT FOOD	Not Payable

61	SLINGS	Reasonable costs for one sling in case of upper arm fractures is payable
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES		
62	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Not Payable
63	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.	Not Payable
64	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Not Payable
65	HORMONE REPLACEMENT THERAPY	Not Payable
66	HOME VISIT CHARGES	Not Payable
67	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Not Payable
68	OBESITY (INCLUDING MORBID OBESITY) TREATMENT	Not Payable
69	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Not Payable
70	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Not Payable
71	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Not Payable
72	DONOR SCREENING CHARGES	Not Payable
73	ADMISSION/REGISTRATION CHARGES	Not Payable
74	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Not Payable
75	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
76	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable
77	STEM CELL IMPLANTATION/ SURGERY	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS PAYABLE		
78	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
79	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
80	MICROSCOPE COVER	Payable under OT Charges, not separately
81	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
82	SURGICAL DRILL	Payable under OT Charges, not separately

83	EYE KIT	Payable under OT Charges, not separately
84	EYE DRAPE	Payable under OT Charges, not separately
85	X-RAY FILM	Payable under Radiology Charges, not as consumable
86	SPUTUM CUP	Payable under Investigation Charges, not as consumable
87	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
88	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
89	SAVLON Not	Payable-Part of Dressing Charges
90	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable
91	COTTON	Not Payable
92	COTTON BANDAGE	Not Payable
93	MICROPORE/ SURGICAL TAPE	Not Payable
94	BLADE	Not Payable
95	APRON	Not Payable
96	TORNIQUET	Not Payable
97	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable
98	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
99	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
100	HVAC	Part of room charge not payable separately
101	HOUSE KEEPING CHARGES	Part of room charge not payable separately
102	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
103	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
104	SURCHARGES	Part of Room Charge, Not payable separately
105	ATTENDANT CHARGES	Not Payable - Part of Room Charges
106	IM IV INJECTION CHARGES	Part of nursing charges, not payable
107	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
108	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
109	BLANKET/WARMER BLANKET	Not Payable- part of room charges

ADMINISTRATIVE OR NON-MEDICAL CHARGES		
110	ADMISSION KIT	Not Payable
111	BIRTH CERTIFICATE	Not Payable
112	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
113	CERTIFICATE CHARGES	Not Payable
114	COURIER CHARGES	Not Payable
115	CONVENYANCE CHARGES	Not Payable
116	DIABETIC CHART CHARGES	Not Payable
117	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
118	DISCHARGE PROCEDURE CHARGES	Not Payable
119	DAILY CHART CHARGES	Not Payable
120	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
121	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
122	FILE OPENING CHARGES	Not Payable
123	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
124	MEDICAL CERTIFICATE	Not Payable
125	MAINTAINANCE CHARGES	Not Payable
126	MEDICAL RECORDS	Not Payable
127	PREPARATION CHARGES	Not Payable
128	PHOTOCOPIES CHARGES	Not Payable
129	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
130	WASHING CHARGES	Not Payable
131	MEDICINE BOX	Not Payable
132	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
133	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
134	WALKING AIDS CHARGES	Not Payable
135	BIPAP MACHINE	Not Payable
136	COMMODE	Not Payable
137	CPAP/ CAPD EQUIPMENTS	Device not payable
138	INFUSION PUMP - COST	Device not payable
139	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
140	PULSEOXYMETER CHARGES	Device not payable