CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
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IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

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Policy Wordings

We issue this Group insurance policy to the Proposer based on the information provided by the Proposer in the proposal form and premium paid by the Proposer. 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/ Organization 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 may be issued to the beneficiaries.

1. PERSONS WHO CAN BE INSURED:

- This Insurance is available to person(s) who has availed any type of loan from Banks/Financial Institutions or such aggregators.
- Coverage under this policy is available for the Borrower/Co-Borrower – Primary Insured, his/her Spouse, Children upto 3 and Parents.
- The Primary Insured should be minimum 18 years on the Commencement date of the policy.
- Primary Member is the main member of the group who has legal relationship with the Group Manager.
- Entry age for the Primary Insured, Spouse and Parents is from 18 years to 70 years of age.
- Children between the age of 03 months to 26 years can be covered under the policy.
- Age means completed years on last birthday as per the English Calendar regardless of the actual time of birth, at the time of commencement of Policy Period, For example, age of 65 years would mean 65 years and 364 days.
- This Insurance provides coverage on Individual Sum Insured basis and in case of family coverage on floater Sum Insured basis.
- On Individual Sum Insured basis, the Borrower/Co-Borrower can cover Self, Spouse, Children upto a maximum of 3 and Parents.
- On Family Floater basis, the Borrower/Co-Borrower can cover Self, Spouse and Children upto a maximum of 3. The Floater Sum insured will float over all the covered family members.
- This policy will be issued for a minimum term of one year upto the loan period not exceeding a maximum of 5 years. The term options under the policy shall be 1,2,3,4 and 5 years.
- The policy can be renewed till the closure of the loan

2. POLICY COVERAGE:

Upon the happening of any of the events stated under the Base Cover during the policy period, we will indemnify the Insured in respect of medically necessary costs as detailed below, up to the limit of Indemnity as mentioned in the Policy Schedule/Certificate and as per the General Conditions of this policy.

BASE COVER

2.1 In patient Hospitalisation Expenses:
This Policy will indemnify for medically necessary inpatient treatment expenses, under different heads mentioned below, incurred during the policy period towards hospitalization for the disease, illness, medical condition or injury

contracted or sustained by the insured person during the Policy Period as stated in the policy Schedule/certificate subject to terms, conditions and exclusions mentioned in the Policy.

a. Room, Boarding charges as provided by the Hospital/Nursing Home in normal rooms or in ICU upto the limits stated in the policy Schedule/certificate.
b. Nursing Expenses incurred during In-Patient hospitalization
c. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees
d. Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, and diagnostic tests)
e. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, and Medicines & Drugs, Diagnostic Materials and Cost of Pacemaker, prosthetic and other devices implanted internally during a surgical procedure.
f. Hospitalisation expenses of the Organ donor during the stay as in-patient solely for the purpose of harvesting the organ, excluding pre and post hospitalisation expenses for such donor.

2.1.a Proportionate Deduction Clause:
If the insured person is admitted in a hospital room where the room rent incurred is higher than the eligible room rent as specified in the policy, then the insured person shall bear the ratable proportion of the total variable medical expenses excluding medicines and consumables including implants in the proportion of the difference between the room rent actually incurred and the room rent specified in the policy.

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

1. Accident / Accidental 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. Associated Medical Expenses means charges incurred for Nursing Care and RMO charge and does not include cost of materials during Inpatient hospitalisation of the Insured.

4. AYUSH Treatment refers to the medical and / or hospitalisation treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems'.

5. 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

6. Bank means a banking Company which transacts the business of banking in India

7. Base Sum Insured means the Sum Insured as specified in the Policy Schedule/Certificate against the respective base covers.

8. 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.

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

10. Commencement Date means the commencement date of this Policy as specified in the Schedule/Certificate.

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

12. 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.

13. Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-

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

14. 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.

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

16. Dependents means only the family members listed below, who is related to Primary Insured or proposer.

- Legally married Spouse as long as he or she continues to be married to you
- Dependent Children who is financially dependent on you.
- Dependent Parents who is financially dependent on you

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.

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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 thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

20. Domiciliary Hospitalisation means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:

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

21. 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.

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 is excluded from the hospital list of the company, due to fraud or moral hazard or misrepresentation indulged by the hospital.

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

25. Family means and includes the Borrower/Co-Borrower, his/her legally married Spouse, Dependent Children and Dependent Parents.

26. Financial Institution shall have the same meaning assigned to the term under section 45 I of the Reserve Bank of India Act, 1934 and shall include a Non Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934.

27. 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.

28. Hospital means any institution established for inpatient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;

- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

29. 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.

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

31. 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.

32. Inception Date means the commencement date of the coverage under this Policy as specified in the Policy Schedule/Certificate.

33. 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.

34. In Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

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

37. Loan means the sum of money lent at interest or otherwise to the Insured by any Bank/Financial Institution as identified by the Loan Account Number referred to in the Policy Schedule/Certificate of Insurance of this Policy. If the Loan amount pertains to Assets, it shall mean to include Assets in India Only.

38. Master Policy Schedule / Policy Schedule means schedule attached to and forming part of this Policy mentioning the details of the Proposer/Group Manager, the Sum Insured, Period and limits upto which the benefits under the policy would be payable.

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

40. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

41. Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
The registered Practitioner should not be the insured or close family members of the insured. For the purpose of this definition, close family members would mean and include the Insured person's Spouse, children (including adopted and step children), Parents, brother, sister, father in law, mother in law, sister in law, brother in law, son in law, daughter in law, uncle, aunt, grandfather, grandmother, grandson, granddaughter, nephew, and niece.

42. Medically necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

a. is required for the medical management of the illness or injury suffered by Insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a medical practitioner;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

45. Migration means 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.

46. Network Provider/ Hospital means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility. The list is available with the insurer and subject to amendment from time to time.

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

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

49. OPD treatment means the one in which the Insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

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

51. 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.

52. Policy period means the period between the commencement date and earlier of

a. The Expiry Date specified in the Policy Schedule/Certificate
b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (5.4.25) below.

53. Policy Certificate/Certificate of Insurance 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 it, shall also be a part of the Policy Certificate.

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

55. 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.

56. Post-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that

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

57. Pre-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Person, provided that

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

58. 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.

59. Proposal Form / Enrolment Form is the form in which the details of the insured person are obtained for a Health Insurance Policy. This also includes information obtained over phone or on the internet and stored on any electronic media and forms basis of issuance of the policy

60. Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

61. 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.

62. 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.

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

64. Sum Insured means the amount shown in the policy schedule/certificate which shall be our maximum liability. In relation to individual policy, it is our maximum liability for each Insured Person for any and all benefits claimed for during the Annual Period (i.e. per annum for multi year tenure) within the policy period and in relation to a Family Floater it is our maximum liability for any and all claims made by the Insured Borrower/Co-Borrower and his dependents during the Annual Period (i.e. per annum for multi year tenure) within the Policy Period.

65. 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

66. 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.

67. 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.

4. WAITING PERIODS & EXCLUSIONS:

4.1 WAITING PERIODS

i. **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.

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 as below

1. Congenital Internal Anomaly,
2. Varicose veins and Varicose Ulcers
3. Rheumatism and arthritis of any kind
4. Treatment of diseases on ears/ tonsils /adenoids /paranasal sinuses / Deviated Nasal Septum
5. Stones in the Urinary and Biliary systems
6. Gastric or Duodenal Ulcer
7. Any type of benign Cyst/ Nodules/ Polyps/ Tumours/ Breast Lumps
8. Intervertebral Disc Prolapse, and Degenerative Disc / vertebral Disorders
9. Cataract
10. Benign Prostatic Hypertrophy
11. Myomectomy, Hysterectomy unless because of malignancy
12. Dilatation and curettage (D&C)
13. Anal Fistula, Fissure and Piles
14. All types of Hernia
15. Hydrocele
16. Chronic Renal Failure
17. Joint replacement Surgery unless because of accident

4.3 Pre-Existing Diseases – Code – Excl01:

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

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

c) If the Insured Person is continuously covered without any break as defined under the 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.

4.4 GENERAL EXCLUSIONS:

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

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:
   b. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   c. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3. **Obesity/Weight Control: Code – Excl06**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1. Surgery to be conducted is upon the advice of the Doctor
   2. The surgery/Procedure conducted should be supported by clinical protocols
   3. The member has to be 18 years of age or older and
   4. Body Mass Index (BMI);
      a) Greater than or equal to 40 or
      b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe sleep Apnea
         iv. Uncontrolled Type2 Diabetes
4. **Change-of-Gender treatments: Code – Excl07**: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
5. **Cosmetic or plastic Surgery: Code – Excl08**: 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.
6. **Hazardous or Adventure sports: Code – Excl09**: 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.
7. **Breach of law: Code – Excl 10**: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers: Code – Excl11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses upto the stage of stabilization are payable but not the complete claim.
9. **Code – Excl12**: Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
10. **Code – Excl13:** 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.
11. **Code – Excl14** 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.
12. **Refractive Error: Code – Excl15**: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
13. **Unproven Treatments Code – Excl16**: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14. **Sterility and Infertility: Code – Excl17**: Expenses related to Sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization
15. **Maternity: Code – Excl18:**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
16. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of the Insured Person's family like, spouse, daughter, son, father, mother, father-in-law, mother-in-law & siblings
17. Dental treatment or surgery of any kind unless necessitated due to accidental injuries and requiring hospitalization.
18. Any expenses incurred towards hearing aids, eyeglasses or contact lenses
19. Circumcisions (unless necessitated by illness or injury and forming part of treatment).
20. Pre & Post hospitalisation expenses of the organ donor and consequential loss to such organ donor.
21. Any travel or transportation costs or expenses.
22. intentional self-injury or attempted suicide whether sane or insane.
23. Conditions for which treatment could have been done on an OPD basis without any Hospitalisation and Outpatient treatment.
24. Congenital anomaly /illness / diseases / condition which are external.
25. Any treatment or investigation taken outside India.
26. Vaccination or inoculation unless forming a part of post-animal bite treatment
27. Injury / illness directly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (whether war be declared or not), ionising radiation, contamination by Radioactive material, nuclear

fuel or nuclear waste or from the combustion of nuclear fuel, civil war, revolution, insurrection, mutiny, martial law.

28. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
29. Non medical Expenses incurred during Hospitalisation. The list of such Non medical Expenses is placed at Annexure1.

5. GENERAL CONDITIONS

5.1. CONDITIONS PRECEDENT TO THE CONTRACT:

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

2. 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.

3. Cost of Pre-Policy Medical Check up

- Pre-Policy Medical Check up for the proposed customers will be arranged by our Designated Service Provider on Cashless basis.
- No cost will be collected from the Customers towards the same.
- In case after undergoing the Pre-Policy Medical Check-up the Proposal gets rejected by us or Insured decides not to take the policy, the expenses incurred by the Insurer for the purpose of Pre-Policy Medical Check-up will be deducted from the Insured's premium and the balance premium would be refunded.

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

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

5.2. CONDITIONS APPLICABLE DURING THE CONTRACT:

5. Notification
a. Any and all notices and declarations for the attention of the Insurer shall be in writing and shall be delivered to the Insurer's address as specified in the Policy Schedule/Certificate.
b. Any and all notices and declarations for the attention of the Policy holder or any or all of the insured Persons shall be in writing and shall be sent to the Policy holder's/Insured's address as specified in the Schedule/Certificate.

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

7. 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.

8. 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.

9. 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.

10. 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**.

11. 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.

12. Territorial Limits

The **Insurer's** liability to make any payment will be within India and in Indian Rupees only for medical services or procedures rendered in or undertaken within India.

13. Assignment:

The policy can be assigned subject to applicable laws.

5.3. CONDITIONS WHEN A CLAIM ARISES:

14. Claim Procedure

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

a. Give us notice of the claim irrespective of notice provided to any other insurer for the same illness in case you are holding multiple insurance policies.

b. Expeditiously give or arrange for us to be provided with any and all information and documentation in respect of the claim and/or our liability for it that may be requested by the Us.

c. 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.

a. 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.

b. 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. Insured hereby acknowledge and agree that the payment of any claim by or on behalf of us shall not constitute on the part of us any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by You, it being agreed and 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. The claims if any occurring during the period of break in insurance shall not be payable under the renewed policy
7. 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

c. Claim Settlement (Provision for penal interest):

i. The Company shall settle or reject a claim ,as the case may be, within 30 days from the date of receipt of last necessary document
ii. In case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the Financial Year in which claim has fallen due)

d. TPA:

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

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

Toll Free Phone No : **1800-208-5544**
Toll Free FAX No : **1800-425 -22 00** (For Cashless Request)
E-Mail : help@cholams.murugappa.com

Address of Chola MS Health Claims Office:
Cholamandalam MS General Insurance Company Limited
Chola MS HELP – Health Claims Department
New No.319, Old No.154, Shaw Wallace Building,
2nd Floor, Thambu Chetty Street, Parry's Corner,
Chennai - 600001
Customer Care Toll Free No: 1800-208-5544
E-Mail: help@cholams.murugappa.com

15. 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 wherever deemed necessary for loss assessment. This will enable us to render prompt service by way of quick and fair settlement of claim, which is our primary motto.
Any genuine delay, beyond the **Insured's** control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Insured's end and especially if the delay has hindered conducting investigation on time to make proper assessment, to mitigate further loss, if any may not only delay the claim settlement but also may result in claim getting rejected on merits.

16. Authority to Obtain Records

The insured must procure and cooperate with us in procuring any medical records and information from the hospital relating to the treatment for which the claim has been lodged. If required, the **Insured Person** should give consent to us to obtain Medical records / opinion from the Hospital directly relating to the treatment for which claim has been made.
If required the Insured / Insured Person must agree to be examined by a Medical Practitioner of Company's choice at our expense

17. Any one illness / relapse period

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

18. Health Cards
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 I**nsured 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.

19. 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.

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

5.4. CONDITIONS FOR RENEWAL OF THE CONTRACT:

21. Renewal of Policy:

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

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.

22. 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.

23. 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.

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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24. Enhancement of Sum Insured:
Sum insured can be enhanced only at the time of renewal subject to reported claim status and health condition of the **insured**. If the **Insured** decides to increase the **Sum Insured** 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 days, 2 years and 4 year waiting periods as per section 4.1.i, 4.1.ii, 4.1.iii of the Policy Terms.

25. 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 (in Months)	Short period Scale - Rate of Premium to be retained				
	1 Year Policy Term	2 Year Policy Term	3 Year Policy Term	4 Year Policy Term	5 Year Policy Term
1	8%	4%	3%	2%	2%
2	17%	8%	6%	4%	3%
3	25%	13%	8%	6%	5%
4	33%	17%	11%	8%	7%
5	42%	21%	14%	10%	8%
6	50%	25%	17%	13%	10%
7	58%	29%	19%	15%	12%
8	67%	33%	22%	17%	13%
9	75%	38%	25%	19%	15%
10	83%	42%	28%	21%	17%
11	92%	46%	31%	23%	18%
12	100%	50%	33%	25%	20%
13		54%	36%	27%	22%
14		58%	39%	29%	23%
15		63%	42%	31%	25%
16		67%	44%	33%	27%
17		71%	47%	35%	28%
18		75%	50%	38%	30%
19		79%	53%	40%	32%
20		83%	56%	42%	33%
21		88%	58%	44%	35%
22		92%	61%	46%	37%
23		96%	64%	48%	38%
24		100%	67%	50%	40%
25			69%	52%	42%

26			72%	54%	43%
27			75%	56%	45%
28			78%	58%	47%
29			81%	60%	48%
30			83%	63%	50%
31			86%	65%	52%
32			89%	67%	53%
33			92%	69%	55%
34			94%	71%	57%
35			97%	73%	58%
36			100%	75%	60%
37				77%	62%
38				79%	63%
39				81%	65%
40				83%	67%
41				85%	68%
42				88%	70%
43				90%	72%
44				92%	73%
45				94%	75%
46				96%	77%
47				98%	78%
48				100%	80%
49					82%
50					83%
51					85%
52					87%
53					88%
54					90%
55					92%
56					93%
57					95%
58					97%
59					98%
60					100%

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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.

26. 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

27. Portability
The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, atleast 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

28. Moratorium Period
After completion of eight continuous years under the policy no look back to 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 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

29. Arbitration
a. Any dispute or difference between the **Insurer** and the **Insured Person** or the Policy Holder 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.

30. Automatic Termination

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This **policy** shall terminate immediately on the earlier of the following events irrespective of the expiry date mentioned in the **Policy Schedule/Certificate**

• Upon the demise of the covered person, in which case the **Company** will refund premium calculated on pro-rata basis for the unexpired period subject to no claim under the policy.
• Upon exhaustion of the Sum Insured. However this will not affect the renewal for the subsequent period.

31. Validity of Cover

The cover under the policy for the member will terminate at the earliest of the following occurrence

- the expiry date mentioned in the Policy Certificate
- in case of death of the Insured
- Date of cancellation of the policy either by the Insured or Policy Holder or Insurer as per policy terms and conditions

6. GRIEVANCES REDRESSAL MECHANISM

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/

List of Ombudsman Office	
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
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
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

7. Annexure-1 *(attached to and forming part of policy wordings)*

LIST I – NON MEDICAL EXPENSES EXCLUDED UNDER THE POLICY	
Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS

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

8. OPTIONAL COVERS

Notwithstanding anything to the contrary contained in the Policy, In consideration of payment of additional premium, the policy is extended to cover the optional benefits listed below upto the sum insured's shown within the policy schedule/certificate.

Endorsement no.1- Pre-Hospitalisation Expenses:

In consideration of payment of additional premium, it is hereby understood and agreed that this policy will pay for medical expenses incurred upto the maximum number days and upto the base sum insured as stated in the policy Schedule/Certificate prior to the date of Hospitalisation provided that

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

This benefit shall be over and above the Base Sum Insured

Endorsement no.2- Post-Hospitalisation Expenses:

In consideration of payment of additional premium, it is hereby understood and agreed that this policy will pay for for medical expenses incurred upto the maximum number of days and upto the base sum insured as stated in the policy Schedule/certificate from the date of discharge from the hospital provided that

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

This benefit shall be over and above the Base Sum Insured

Endorsement no.3- Emergency Ambulance Expenses:

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In consideration of payment of additional premium, it is hereby understood and agreed that this policy will pay for Ambulance Expenses actually incurred to transfer the **Insured Person** to Healthcare facility, inter Healthcare facility transfer or from Healthcare facility to insured residence upto a limit as stated in the policy schedule/certificate per hospitalisation per person, following an emergency to the nearest **Hospital** with adequate facilities, provided that:

a) The ambulance service is offered by a healthcare or an ambulance service provider.
b) The Inpatient **Hospitalization** claim for such Hospitalization is admissible by **Us**

Ambulance Expenses will be reimbursed to the **Insured** on submission of original bills. Cashless facility will not be available for Ambulance Expenses/Services.

This benefit shall be over and above the Base Sum Insured

Endorsement no.4 - Day Care Procedures / Treatment Expenses:

In consideration of payment of additional premium, it is hereby understood and agreed that this policy will pay for Medical Expenses incurred as a Day Care Procedure/Treatment that requires less than 24 hours of hospitalization due to advancement in technology and which is undertaken in a Hospital/Day Care Center on the recommendation of a Medical Practitioner, upto Base **Sum Insured** as stated in the **policy schedule/certificate,** if it is performed in a network hospital. In case the procedure is performed in a non network hospital, the same must be pre-authorised by us. Pre-authorisation has to be obtained 72 hours prior to the date of admission in case of planned admission and within 24 hours in case of emergency admission.

This benefit shall be over and above the Base Sum Insured

Endorsement no.5 – AYUSH Coverage Expenses:

In consideration of payment of additional premium, it is hereby understood and agreed that this policy will pay for Hospitalisation expenses that require more than 24 hours of Hospitalisation for illness or accidental bodily injury for non-allopathic treatments given under Ayurveda, Unani, Siddha and Homeopathy systems upto the Base Sum insured as stated in the **policy schedule/certificate**. The treatment should have been undergone in AYUSH Hospital as defined below:

AYUSH Hospital:
An AYUSH Hospital is a healthcare facility wherein medical/surgical/parasurgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
a) Central or State Governmental AYUSH Hospital; or
b) Teaching hospital attached to AYUSH College recognised by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognised system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily/records of the patients and making them accessible to the insurance company's authorised representative.

This benefit shall be over and above the Base Sum Insured

Endorsement no.6 – Domiciliary Hospitalisation Expenses:

In consideration of payment of additional premium, it is hereby understood and agreed that this policy will reimburse the Medical Expenses incurred by an **Insured Person** for medical treatment taken at his/her home which would otherwise have required Hospitalisation upto a maximum 10% or 20% or 25% of Base Sum Insured or Rs. 5 Lakhs, whichever is lower, as stated in the Policy Certificate, provided:

a) on the advice of the attending Medical Practitioner, the **Insured Person** could not be transferred to a Hospital or
b) a Hospital bed was unavailable, and provided that:
   I. The condition for which the medical treatment is required continues for at least 3 days, in which case the Policy pays reasonable cost of necessary medical treatment for the entire period of Domiciliary Hospitalisation.
   II. Pre-hospitalisation and Post-hospitalisation expenses in accordance with Endorsement no. 1 and 2 respectively if opted will be covered under this benefit.
   III. No payment will be made under this benefit if the condition for which the Insured Person requires medical treatment towards following ailments:
      1. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza
      2. Arthritis, Gout and Rheumatism,
      3. Chronic Nephritis and Nephritic Syndrome,
      4. Diarrhoea and all type of Dysenteries including Gastroenteritis,
      5. Diabetes Mellitus and Insupidus,
      6. Epilepsy,
      7. Hypertension,
      8. Pyrexia of unknown Origin.

Cashless facility will not be available for such a claim.

This benefit shall be over and above the Base Sum Insured

Endorsement no.7 - Sum Insured Restoration for unrelated claims:

In consideration of payment of additional premium, it is hereby understood and agreed that this policy will provide for a 100% restoration of Sum Insured during the policy year, provided that:

a. The Base Sum Insured is insufficient or exhausted as a result of previous claims during the policy year.
b. The Restored Sum Insured shall not be available for claims towards an Illness/ disease/ Injury (including its complications) for which a claim has been paid during the policy year for the same Insured Person.

c. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under basic **Inpatient Hospitalisation Expenses cover** and shall not apply to the first claim in the Policy Year.
d. No Restoration of the Sum Insured will be provided for covers other than Basic Inpatient Hospitalisation expenses
e. Sum Insured Restoration is applicable only for the current policy year and any unused Sum Insured cannot be carried forward to the next policy year. This policy does not cease on payment of claim under this benefit.
f. Such restoration of Sum Insured will be available only once during a Policy Year to each insured in case of an individual Sum Insured. If the Policy is issued on a floater basis, the Restored Sum Insured will be available on a floater basis.
g. Sum Insured for any Accident claims resulting in Inpatient Hospitalisation shall be restored upto 25% of the Base Sum Insured or upto Rs.3 Lakhs whichever is lower.

All Claims under this benefit can be made as per the process defined under 'Condition when a claim arises' section.

This cover is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.

Endorsement no.8- Recharge Benefit for related claims:

In consideration of payment of additional premium, it is hereby understood and agreed that in the event of exhaustion of the Base Sum Insured during the policy period, recharge benefit as stated in the Policy Certificate will be provided once during the policy year for reimbursement of medical expenses under basic **Inpatient Hospitalisation Expenses** for treatment of same disease, illness, medical condition or injury for which claim was paid under the policy during the policy period.

Specific Conditions applicable to Recharge Benefit for related claims:

1. No Recharge benefit will be provided for covers other than Basic Inpatient Hospitalisation expenses
2. This benefit will be triggered on exhaustion of the Sum Insured under the policy.
3. Recharge Benefit is applicable only for the current policy year and any unused Sum Insured cannot be carried forward to the next policy year. This policy does not cease on payment of claim under this benefit.
4. Such Recharge Benefit will be available only once during a Policy Year to each insured in case of an individual Sum Insured. If the Policy is issued on a floater basis, the Recharge Sum Insured will be available on a floater basis.
5. Recharge benefit for any Accident claims resulting in Inpatient Hospitalisation shall be upto 25% of the Base Sum Insured or upto Rs.3 Lakhs whichever is lower.

All Claims under this benefit can be made as per the process defined under 'Condition when a claim arises' section.

This cover is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.

Endorsement no.9- Hospital Daily Cash Benefit:

In consideration of payment of additional premium, it is hereby understood and agreed that in the event of hospitalisation of the **Insured Person**, the **Company** will pay the Hospital Daily Cash benefit. This benefit shall be

paid for each continuous and completed period of 24 hours of Hospitalisation for a maximum period of 7 or 15 or 30 days (as opted) per person per policy year. The limits under this section are as mentioned below:

Per day limit: Rs Rs Rs.250/- per day in multiples of Rs.50/- upto a Maximum of Rs.5000/- as opted and mentioned in the policy Schedule/Certificate
In case of stay in ICU, the chosen per day limit shall be increased by 100%.

This benefit is subject to the hospitalization related to disease, illness, medical condition or injury contracted or sustained by the Insured person during the policy period as stated in the policy schedule/certificate and for which there is a valid claim admitted under the basic **Inpatient Hospitalisation Expenses** cover of the policy.

This benefit shall be over and above the Base Sum Insured

Endorsement no.10- Compassionate Travel:

In consideration of payment of additional premium, it is hereby understood and agreed that in the event of the hospitalisation of the insured for a **Life threatening Medical Emergency** at a place away from his usual place of residence as recorded in the policy, the policy will reimburse the transportation expenses incurred for air travel upto the maximum limit as stated in the Policy Certificate for one of the immediate family member (other than the travel companion) to travel to the hospital, provided the claim for Hospitalisation is admissible under the Base In patient hospitalisation cover of the policy.

The benefit amount mentioned in the Policy Certificate will be the maximum limit applicable per policy year (per annum in case of multi-year tenure).

In relation to individual policy it is our maximum liability for each Insured Person per policy year (i.e., per annum for multi year tenure) and in relation to a Family Floater it is our maximum liability for the all the Insured Persons covered under the policy per policy year (i.e., per annum for multi year tenure).

Definitions applicable to Compassionate Travel:

1. **Life Threatening Medical Emergency** means a medical condition potentially fatal which could result in death of the life of the **Insured.**

2. Immediate **family member** shall mean and include the **Insured Person's** Spouse, children (including adopted and step children) and parents.

This benefit will be available only on reimbursement basis.

This benefit shall be over and above the Base Sum Insured

Claim documentation applicable to this endorsement in addition to duly filled in and signed claim and KYC documents are as follows:

1. Original ticket issued by common carrier for travelling from the place of residence to the place where the insured is hospitalised.

Endorsement no. 11- Repatriation of Mortal Remains:

This policy will reimburse the actual expenses subject to a maximum of Rs.3000/- incurred for transportation of mortal remains of the Insured Person from the hospital to the residence and/or cremation and/or burial ground subject to an admissible claim under basic Inpatient Hospitalisation cover.

This benefit will be available only on reimbursement basis.

This benefit shall be over and above the Base Sum Insured

Endorsement no. 12- Maternity Benefit:

In consideration of payment of additional premium, it is hereby understood and agreed that the policy will pay for medical expenses for delivery (including caesarean section) or the lawful medical termination of pregnancy, (without threat to mother or child's life) while hospitalized, during the policy period excluding elective termination, limited to 2 deliveries or terminations or either one of each during the lifetime of the Insured.

This will include pre-natal and post-natal expenses per delivery or termination and medically necessary treatment of the new born baby within the policy period provided that

a. Maximum liability per delivery or termination shall be limited to the amount as stated in the Policy Schedule/Certificate
b. Pre- and post-hospitalisation expenses are not covered under this benefit.
c. A waiting period of 9 months is applicable for any claim to be payable under this coverage

This benefit shall be over and above the Base Sum Insured

Further it is also hereby declared and agreed that General Exclusion no.15 Maternity: Code – Excl18 of the policy shall stand deleted.

Endorsement no. 13- Outpatient Benefit:

In consideration of payment of additional premium, the policy will indemnify the medical expenses incurred by the Insured towards the following Outpatient care services subject to the maximum limit as mentioned in the Policy Schedule / Certificate

a. Out Patient Consultations
b. Diagnostic Examinations prescribed by the Medical Practitioner
c. Pharmacy prescribed by the Medical Practitioner

Cashless facility will not be available for such a claim. Under a Family Floater policy, the limits under this benefit will represent our maximum liability for any and all claims made by the Insured Borrower/Co-Borrower and his/her dependants during the policy year.

The maximum liability under this benefit will be limit as mentioned in the policy certificate for the policy year.

This benefit shall be over and above the Base Sum Insured.

Claim documentation applicable to this endorsement in addition to duly filled in and signed claim and KYC documents are as follows:

1. Consultation papers
2. Diagnostic Reports with Dr.'s prescription
3. Pharmacy bills with Dr.'s prescription

Endorsement no. 14- No Proportionate Deduction:

In consideration of payment of additional premium, it is hereby agreed and declared that the Proportionate deduction clause applicable under basic Inpatient Hospitalisation expenses cover shall stand deleted for the Insured Persons covered under the Policy as stated in the Policy Certificate.

Endorsement no. 15- Medical Second Opinion:

In consideration of payment of additional premium, it is hereby agreed and declared that in the event of any Insured Person, being diagnosed with any Medical Condition during the Policy Year, he or she can obtain the Medical Second Opinion from the World's Leading Medical Centers (WLMC) tied up with our Service Provider.

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

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

This benefit is available for each insured person covered under Individual or Family Floater policy.

Specific Conditions applicable to Medical Second Opinion:
The coverage under this policy is subject to the following special conditions

1. This policy shall not provide medical second opinion in respect of illnesses for which the Insured member is undergoing treatment at the time of taking the policy.
2. Medical Second Opinion should be specifically requested for by the Insured.
3. The Insured is free to choose whether or not to obtain the Second Opinion and, if obtained under this cover, then whether or not to act on it.
4. This opinion is given based only on the medical records submitted without examining the patient, who is covered under the policy.
5. This benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured's visit or consultation to an independent Medical Practitioner.
6. Any Medical Second Opinion provided hereunder shall not be valid for any medico-legal purposes or any insurance claim purposes.
7. Medical Second Opinion under this cover is facilitated by the Service Provider from the WLMC and not provided by the Company.

8. The Company does not make any representation as to the adequacy or accuracy of the Medical Second Opinion or the Insured's or any other person's reliance on the same or the use to which the Second Opinion is put.
9. The Company is not liable for any claims due to any errors or omission or consequences of any action taken or not taken in reliance of the Medical Second Opinion provided under this cover.
10. Utilizing this facility alone will not amount to making a claim under any health insurance policy.
11. No medical Second Opinion can be availed during the break in insurance

Specific Exclusions applicable to Medical Second Opinion:
The Service Provider will not facilitate Medical Second Opinion with the WLMC in the following circumstances where the

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

Definitions applicable to Medical Second Opinion:

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

Procedure to obtain Medical Second Opinion:
In order to obtain the Medical Second opinion,

- Insured has to contact the Service Provider through the Toll Free number mentioned on the Policy Schedule and provide the
  - Clinical information details,
  - Authorisation to collect medical records from the hospital or attending physician or health care provider and

- Consent to share the medical records with the WLMC for review and provide Medical Second Opinion by email.

- Based on the Clinical information shared by the Insured, Service Provider will give a choice of 3 World Leading Medical Centers to the Insured, from which the Insured will have an option to choose one WLMC to obtain the Medical Second Opinion.
- WLMC selected by the Insured will review the medical records and write a detailed report with recommendations (Medical Second Opinion).
- Medical Second Opinion received from the WLMC will be sent through secured email to the Insured by the Service Provider with translated version, if required.

In addition to the Medical Second Opinion, the Service Provider will also arrange to send a casebook by courier to the Insured Person's address within 10 days from the date of providing medical second opinion by email.

The casebook will consist of the following documents

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

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

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

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

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

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

Endorsement no. 16 - Co-Payment:
The Group Manager / Policyholder shall have an option for a Co-Payment % as opted and mentioned on the Policy Certificate, which shall be applicable on every admissible Claim.

Endorsement no. 17 - Pre-existing Waiver with Co-Payment:
On Consideration of payment of additional premium, it is hereby understood and agreed that the Waiting Period applicable for claims due to Pre-existing Disease/Condition shall be waived and any admissible claim shall be subject to a Co-Payment % as opted and mentioned on the policy certificate.

This Co-Payment shall be in addition to the Co-Payment opted vide Endorsement no.16, if any.

Endorsement no. 18 - Waiver of Initial Waiting Period of 30 days:
On Consideration of payment of additional premium, it is hereby understood and agreed that the Waiting Period applicable for claims arising due to illness and falling within the 30 days from the first policy commencement date as per Waiting Period 4.1.i. shall stand waived.

This is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.

Endorsement no. 19 – Waiver of Specific Waiting Period for listed illness:
On Consideration of payment of additional premium, it is hereby understood and agreed that the Waiting Period of 12 months applicable for the illness listed under Waiting Period 4.1.ii, shall stand waived.

This cover is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.

Endorsement no. 20 – Waiver of Pre-existing Disease/Condition without Co-Payment:
On Consideration of payment of additional premium, it is hereby understood and agreed that the Waiting Period of 48 months applicable for claims due to Pre-existing Disease/Condition as per waiting period 4.1.iii, shall be reduced to 36/24/12/NIL Months as opted and mentioned on the Policy Schedule / Certificate.

This cover is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.

Endorsement no. 21 – Waiver of waiting period for Endorsement no.12 - Maternity cover:
On Consideration of payment of additional premium, it is hereby understood and agreed that the Waiting Period of 09 months applicable for Maternity cover vide endorsement no. 12, shall stand waived.

This cover is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.

Endorsement no. 22 – Waiver of Pre Medical Health Checkup:
On Consideration of payment of additional premium, it is hereby understood and agreed that the Pre Policy Medical Checkup applicable for persons above 50 years of age and / or for Sum Insured above 50 Lakhs shall stand waived.
This cover is subject otherwise to the terms, exceptions, conditions and limitations of the Policy.