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

CHOLA TOP UP HEALTHLINE
CHOHLIP21306V022021
POLICY WORDINGS

CHOLA TOP UP HEALTHLINE

SECTIONS:

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Section 1 : Customer Information Sheet

S No	Title	Description	Policy Clause Number
1	Product Name	Approved Brand Name	Chola Topup Healthline
2	What am I covered for:	Hospital Expenses	Section 3 Coverages 3.1.1
		Related medical expenses incurred 60 days prior to date of admission	Section 3 Coverages 3.1.2
		Related medical expenses incurred 90 days from date of discharge	Section 3 Coverages 3.1.3
		Ambulance Expenses	Section 3 Coverages 3.1.45
3	What are the Major exclusions in the policy:	Circumcision unless necessary for the treatment of an Illness not otherwise excluded in this Section, or required as a result of Accidental Bodily Injury	Section 5 General Exclusion 5.c.16
		Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Excl12**	Section 5 General Exclusion 5.c.6
		Change-of-Gender treatments: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. **Code – Excl07**	Section 5 General Exclusion 5.c.4
		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	Section 5 General Exclusion 5.c.11
		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);Greater than or equal to 40 or 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	Section 5 General Exclusion 5.c.3

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		Sexually transmitted disease or illness Refer policy wordings for detailed list of exclusions	Section 5 General Exclusion 5.c.20
4	Waiting period	Initial Waiting period: 30 days for all illness (not applicable on renewal and for accidents)	Section 5 General Exclusions a.Waiting Periods I
		Specific Waiting period: - 12 months for listed disease - 24 months for listed disease	Section 5 General Exclusions a.Waiting Periods II
		Pre-existing diseases: covered after 48 months	Section 5 General Exclusions b.
5	Payment basis	Cashless Hospitalisation	6. General Conditions -6.20 I
		Reimbursement of covered expenses upto specified limits	6. General Conditions -6.20 II
6	Loss sharing	In case of a claim, this policy requires you to share the following costs: - Expenses exceeding the following sub-limits - Per day Room limit of Rs. 500/- under Rs.50,000/- SI, Rs.2000/- under 2 Lacs SI, Rs.4000/- under 3 Lacs SI, Rs.5000/- under 5 Lacs SI, Rs.6000/- under 6 Lacs SI, Rs.7500/- under 10 Lacs SI, Rs.10,000/- under 15 Lacs SI	2. Schedule of Benefits
7	Renewal Conditions	The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person, Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years	6. General Conditions -6.24
8	Renewal Benefits	Not Applicable	Not Applicable
9	Cancellation	The Policy shall be cancelled by us for misrepresentation, fraud, non disclosure of material facts or non co-operation of insured by giving 15 days written notice. The Policy Holder may also cancel the policy at any time during the currency of the policy in which case the refund shall be on short period rates as per Policy condition.	6. General Conditions -6.29
10	Claims	For Cashless Service: Insured can view or download the updated Hospital Network from the Company's website www.cholainsurance.com For Reimbursement of Claim: Claim Documents as listed in the Policy Terms have to be submitted at the earliest possible opportunity not exceeding 30 days from date of discharge.	6. General Conditions -6.20.I ,6.20.II
11	Policy Servicing/ Grievances/ Complaints	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	7.Grievances

		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 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/	
12	Insured's Rights	• Free Look: Insured will have a free look period of 15 days from the date of receipt of this policy to review the terms and conditions of the policy and to return the same if not acceptable. • The policy will be renewed so long as the Insurer receives the premium unless on grounds of misrepresentation, fraud by the Insured. • Migration: Proposer should approach the insurer atleast 30 days before the premium renewal date of his/her existing policy for the purpose of migration Portability: The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability • Sum Insured can be enhanced at the time of renewal subject to reported claim status and health condition of the Insured. • Insured has to send us written request for the above service requests to our customer services at the email id customercare@cholams.murugappa.com or to the Company address as mentioned in the Policy Schedule • Claim Reimbursement: We shall settle claims, including its rejection, within thirty days of the receipt of last `necessary' document. • Cashless Pre-authorisation shall be processed within 24 hours of receipt of the complete medical details from the Service provider	6. General Conditions 6.6,6.24,6.30,6.27,6.28,6.20
13	Insured's	• Insured is at obligation to disclose all pre-existing diseases	6.General Conditions 6.4

	Obligations	or condition in the Proposal form. In the event of misrepresentation, mis-description or non-disclosure of any material fact by the Insured, the Policy shall be void and all premium paid hereon shall be forfeited to the Company and no claims shall be payable. • Insured can contact our Customer Services over phone at the toll free no. 1800 208 5544 or write to us at customercare@cholams. murugappa.com to intimate any change to the material information affecting the policy.	

Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail

We issue this insurance policy to You and/or Your Family based on the information provided by You / Proposer in the proposal form and premium paid by You/ Proposer. This insurance is subject to the following terms and conditions. This policy covers on Individual Sum Insured basis and in case of family coverage on floater Sum Insured basis. The method of coverage and the Sum Insured that has been opted by you is mentioned in the Policy Schedule. The term You/ Your / Insured Person /Insured/ Policyholder/ Proposer in this document refers to You and all the Insured persons covered under this policy. The term Insurer/ Us/ our/ Company in this document refers to Cholamandalam MS General Insurance Company Limited

Section 2 SCHEDULE OF BENEFITS
Benefits in the table below should be read in conjunction with Section 3 Coverages and Section 4 Definitions

Plan Option	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Sum Insured (over Excess) in Rs	50000	2 lacs	3 lacs	5 lacs	6 lacs	10 lacs	15 lacs
Excess in Rs	30000	1 lac	2 lacs	3 lacs	4 lacs	5 lacs	5 lacs
Room charges per day limit in Rs	500	2,000	4,000	5,000	6,000	7,500	10,000
Pre-hospitalisation Expenses	Expenses incurred upto 60 days prior to date of hospitalisation subject to a limit of 5% of claim payable under the policy						
Post-hospitalisation Expenses	Expenses incurred upto 90 days from the date of discharge from hospital subject to a limit of 10% of claim payable under the policy or Rs.50,000/- whichever is less						
Emergency Ambulance	Upto Rs.3000/- per hospitalization						
Entry Age	3 months to 65 years						

Sum Insured means the maximum limit of indemnity or our maximum liability during the policy period, under this policy. This is the actual coverage amount over and above the Excess opted by you.

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Excess means the amount over and above which you agree to make claim for each hospitalisation. We will deduct this amount from the overall admissible claim payable under this policy, for each and every hospitalization claim.

The total amount payable under this policy per year for all sub sections as above put together shall not exceed the Sum insured for the Insured persons (Floater Sum insured in the case of family coverage) as shown in the policy schedule

Remarks	Base Policy SI	Chola Top up Healthline		Total Claim Amount	Claim Paid		Total Claim Paid
		SI	Excess		Base Policy	Top Up	
Case1	200000	500000	300000	750000	200000	450000	650000
Case 2	200000	600000	400000	800000	200000	400000	600000
Case 3	200000	500000	300000	900000	200000	500000	700000

For better understanding of the above table, please go through the below examples:

Example 1
Mr.Kumar (40yrs, working in a pvt. company) has employer-provided health insurance of Rs.3 lakh for his family (self, spouse and 2 children). Let's say he buys a Chola Top Up Healthline Plan D (Rs5 lakh coverage over Rs3 lakh deductible). His family is now covered for an overall SI of Rs8 lakh. In the event of a serious illness requiring hospitalization, Mr.Kumar's family can avail treatment up to Rs.8 lakh in a single claim. The first Rs3 lakh will be covered by his employer's policy and the remaining Rs.5 lakh will be paid by Chola Top Up Healthline.

Example 2
Mr.Shah (30yrs, Shopkeeper) does not have any health insurance. He believes in self financing mode for minor illness leading to hospitalization. But more serious treatments like bypass surgery scare him a lot. Let's say he takes Chola Top Up Healthline Plan B (Rs.2lakh coverage over Rs.1 lakh deductible). In the event of an illness / accident requiring hospitalization, Mr. Shah can avail treatment up to Rs.3 lakh in single claim. The first Rs.1 lakh will be borne by Mr. Shah and remaining Rs.2 lakh will be paid by Chola Top Up Healthline

Section 3 Coverages
3.1 **Inpatient Hospitalization Expenses**
We will pay for hospitalization expenses that require more than 24 hrs of Hospitalization for illness or accidental bodily injury upto Sum insured mentioned in the policy schedule:

a) Doctors' fee
b) Nursing Charges
c) Room Charges (subject to per day limits as mentioned in the Policy Schedule),
d) ICU charges,
e) Diagnostics, Medicines, Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, 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

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3.2 **Pre-Hospitalization Expenses**
We will pay for medical expenses incurred immediately before the Insured Person is Hospitalized upto the number of days mentioned in the schedule of benefits, provided that
a. The expenses were incurred after the first 30 day waiting period as mentioned in Exclusion no 5.1.1
b. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

The Inpatient Hospitalization claim for such Hospitalization is admissible by Us

3.3 **Post-Hospitalization Expenses covers**
We will pay for medical expenses incurred immediately after the Insured Person is discharged upto the number of days mentioned in the Schedule of benefits, provided that

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

3.4 **Emergency Ambulance Expenses**
We will pay for ambulance expenses, as mentioned in the Schedule of benefits, incurred to transfer the insured person following an emergency to the nearest Hospital with adequate facilities, provided that:
a. The ambulance service is offered by a healthcare or an ambulance service provider.
b. We have accepted the inpatient hospitalization claim under point 3.1 above

The claim amount payable shall be the total cost of hospitalisation expenses as per policy terms including sub-limits, less the Excess. In cases where You are already having another indemnity based health insurance policy with any primary insurer and the available sum insured under such a policy is higher than the Excess under this policy, the claim amount payable shall be determined as per condition under section 6.4 point number (c) below.

If the cover is provided as floater cover, the benefits under this insurance are available on Floater basis to the members of the family whose names are mentioned in the Policy Schedule during the policy period, subject to the overall limit of Sum Insured specified.

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

Section 4 : DEFINITIONS
To help You understand Your Policy the following words and phrases used anywhere within Your Policy have specific meanings, which are set out in this section

1) **Accident means** a sudden, unforeseen and involuntary event caused by external, visible and violent mean
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

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3) **Admissible Claim amount** means the eligible amount payable under this policy, to You, up to the Sum Insured, after applying the Excess and sub-limits wherever applicable
4) **Age** means completed years on Your last birthday as per the English Calendar regardless of the actual time of birth, at the time of commencement of Policy Period
5) **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context
6) **Annual Period** refers to a continuous period of insurance of 12 months within the contract period
7) **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken
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) **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
11) **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 anamoly which is not in the visible and accessible parts of the body
    b. **External Congenital Anomaly:** Congenital anamoly which is in the visible and accessible parts of the body
12) **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical set up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under
    a. has qualified nursing staff under its employment ;
    b. has qualified medical practitioner (s) in charge;
    c. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
13) **Day Care Treatment/Procedure** refers to medical treatment and/or surgical procedure which is :
    - Undertaken under General or Local Anaesthesia in hospital / day care centre in less than 24 hours because of technological advancements, and
    - Which would have otherwise required a hospitalisation of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

14) **Dependents** refer to family members listed below, who is financially dependent on the Primary Insured or proposer and does not have his / her independent sources of income. Spouse, dependent children, Parents, Parents-in-law.
15) **Diagnosis** means the identification of a disease/illness/medical condition made by a Medical Practitioner supported by clinical, radiological and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to us
16) **Diagnostic Test** means investigations such as X-ray or blood tests to find the cause of Your symptoms and medical condition

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17) **Disclosure to information norm** means the policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact
18) **Emergency** Care means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
19) **Endorsement** means written evidence of change to the insurance Policy including but not limited to increase or decrease in the policy period, extent and nature of the cover agreed by the Company in writing
20) **Excluded Hospital** means any hospital which is excluded from the hospital list of the company, due to fraud or moral hazard or misrepresentation indulged by the hospital
21) **Family Floater** means a Policy described as such in the Schedule where You and Your Dependents named in the Schedule are insured under this Policy. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period
22) **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
23) **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
24) **Hospital** means any institution established for inpatient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    1. Has qualified nursing staff under its employment round the clock;
    2. 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;
    3. has qualified medical practitioner (s) in charge round the clock;
    4. has a fully equipped operation theatre of its own where surgical procedures are carried out
    5. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
25) **Identification** or **ID card** means the card issued to the Insured Person by the Insurer.
26) **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.
27) **Inception Date** means the commencement date of the coverage under this Policy as specified in the Policy Schedule

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28) **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

29) **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

30) **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.

31) **ICU Charges** - ICU (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

32) **Long Term** means the continuous period of insurance more than 12 months with in the Policy period

33) **Maternity Expenses** shall include
a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization)
b) Expenses towards lawful medical termination of pregnancy during the policy period

34) **Medical Advise** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription

35) **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.

36) **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license

37) **Medically necessary** Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a medical practitioner;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

38) **Membership Number I**dentification number of every insured person for the In-house Claims administration team of the insurer. Membership number will be mentioned in the health card provided to each insured person.

39) **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

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40) **Network 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.
41) **Newborn Baby** means baby born during the Policy Period and is aged upto 90 days.
42) **Non- Network** means any hospital, day care centre or other provider that is not part of the network
43) **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
44) **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
45) **Policy** means the policy schedule (including endorsements if any), the terms and conditions in this document, any annexure thereto (as amended from time to time) and your statements in the Proposal form.
46) **Policy period** means the period between the inception date and earlier of
    a. The Expiry Date specified in the Schedule
    b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (4.29) below.
47) **Policy Schedule** means that portion of the Policy which sets out Your personal details, the type and plan of insurance cover in force, the Policy duration and sum insured etc. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule
48) **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
49) **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
50) **Pre-hospitalisation Medical Expenses m**eans medical expenses incurred immediately before the Insured Person is Hospitalised, provided that
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
51) **Post-Hospitalization Medical Expenses m**eans medical expenses incurred immediately after the Insured Person is discharged from the hospital, provided that
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
52) **Proposer** means the person who has signed in the proposal form and named in the Schedule. He may or may not be insured under the policy

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53) **Proposal Form:** The form in which the details of the insured person are obtained for a Health Insurance Policy. This also includes information obtained over phone or on the internet and stored on any electronic media and forms basis of issuance of the policy
54) **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
55) **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
56) **Renewal** 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.
57) **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses
58) **Schedule of Benefits** means the table of benefits, with the limit of Sum Insured under each benefit, that will be paid by us as per the plan opted by you.
59) **Sum Insured** means the amount shown in the policy schedule which shall be our maximum liability for each Insured Person for any and all benefits claimed for during the policy period and in relation to a Family Floater our maximum liability for any and all claims made by You and all of Your Dependents during the Policy period
60) **Surgery** or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner
61) **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.
62) **Waiting period** refers to the period during which we shall not be liable to make any payment for any claim for treatment. This is not applicable if caused directly due to an accident during the policy period

SECTION 5: General Exclusions
No indemnity is available or payable for claims directly caused by, arising out of or connected to the following:

a. 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:

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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

Illnesses excluded for One year	Illnesses excluded for Two years
Cataract, Hernia / Hydrocele, Benign Prostate Hypertrophy, Hysterectomy (non-malignant), Fistula in Anus, Anal Fissure, Piles, Sinusitis, Gall Bladder Stones, Gastric or Duodenal ulcer, Tonsilitis or Adenoids, Breast lumps, Cysts, nodules or polyps, Congenital internal anomaly / conditions	Hysterectomy for Menorrhagia or Fibromyoma, knee replacement surgery (other than caused by an accident) Joint Replacement Surgery (other than caused by an accident), Arthritis, Spondylosis / Spondylitis, Renal Failure, Hypertension, Diabetes, Prolapse of intervertebral disc (other than caused by accident), Varicose veins and Varicose ulcers

b. 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

c. General Exclusions

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:

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i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. **Obesity/Weight Control: Code – Excl06**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor
   2) The surgery/Procedure conducted should be supported by clinical protocols
   3) The member has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      a) Greater than or equal to 40 or
      b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe sleep Apnea
         iv. Uncontrolled Type2 Diabetes
4. **Change-of-Gender treatments:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. **Code – Excl07**
5. **Cosmetic or plastic Surgery:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner. **Code – Excl08**
6. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Excl12**
7. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl13**
8. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. **Code – Excl14**
9. **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **Code – Excl15**
10. **Unproven Treatments**: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. **Code – Excl16**
11. **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
12. **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.

13. Congenital illness / diseases / condition which are external.
14. Pre & Post hospitalisation expenses of the organ donor and consequential loss to such organ donor.
15. Injury / illness directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (whether war be declared or not), civil war, revolution, insurrection, mutiny, martial law.
16. Circumcision unless necessary for the treatment of an Illness not otherwise excluded in this Section, or required as a result of Accidental Bodily Injury.
17. Vaccination or inoculation unless forming a part of post-animal bite treatment
18. Cost of spectacles and contact lens, hearing aids, walkers, crutches wheel chairs.
19. Dental treatment or surgery of any kind unless necessitated due to accidental injuries and requiring hospitalization.
20. Sexually transmitted disease or illness
21. Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons / materials.
22. Non-allopathic treatments.
23. Hospital registration charges, record charges telephone charges and such other charges which are not part of the treatment and which are charged separately.
24. Domiciliary treatment and also treatments taken outside India
25. Non medical Expenses incurred during Hospitalisation. The list of such Non medical Expenses is placed at Annexure 1

SECTION 6 : General Conditions

I. 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. Due Care

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

3. Change of Address / Contact details

It is in the interest of the proposer to intimate to the insurer any change in residential address and phone number(s)

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 the insured person shall be entitled to refund of pro-rata premium for the unexpired portion of the policy on the date of cancellation.

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5. Cost of Pre Insurance Health Check Up

Based on acceptance of the proposal and issuance of policy, we would reimburse to the insured 50% of the cost of examinations as per the plan selected. This will be provided as refund of expenses for pre-policy health check-up to the proposer after policy issuance. Original receipt for medical tests undergone is required to be submitted to us for reimbursement. This has to be claimed within 30 days of approval of policy.

6. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. A refund of premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

7. Specific and Permanent Exclusions

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

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

8. Moratorium Period

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

9. Disclosure of Information

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

II. CONDITIONS APPLICABLE DURING THE CONTRACT

10. 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.

11. Notification

i. Any and all notices and declarations for the attention of the Insurer shall be in writing and shall be delivered to the Insurer's address as specified in the Schedule.

ii. Any and all notices and declarations for the attention of any or all of the insured Persons shall be in writing and shall be sent to the Policyholder's address as specified in the Schedule.

12. Transfer

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

13. 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.

14. 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:

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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.

15. 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

16. 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.

17. 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.

18. Territorial Limits

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

19. Assignment

The Policy can be assigned subject to applicable laws

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III. CONDITIONS WHEN A CLAIM ARISES

20. 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:

1. Give us notice of the claim at the earliest irrespective of notice provided to any other insurer for the same illness in case you are holding multiple insurance policies ;
2. 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
3. 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
4. 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.

I. 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.

II. Procedure for submission of Reimbursement Claims

1. Upon Hospitalisation, the insured Person or his/her dependents shall provide us with fully particularised details of the quantum of any claim to be reimbursed and any and all other information and documentation in respect of the claim and/or our liability for it sought by our In-House Claims team at the earliest possible opportunity not exceeding 30 days from date of discharge.
2. We shall be under no obligation to pay or arrange to make payment for any claim until and unless it is satisfied as to the validity and quantum of Your claim.
3. The Insured shall obtain and furnish to the Company all copy of bills, receipts and any other documentation upon which a claim is based. `Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The expenses towards doctors' fees for any additional medical examination required by us, at the time of claim shall be borne by us.
4. We shall only make payment (unless already paid direct to the service provider/hospital) to You or your Nominee.
5. You acknowledge and agree that the payment of any claim by or on behalf of us shall not constitute on the part of us any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by You, it being agreed and recognised by You that we are not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution (including a Network Hospital) whether pre-authorised or not.
6. Following documents are to be submitted for processing of the claim:

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- 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

III. Claim Settlement(Provision for penal interest)

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

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

IV. TPA

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

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

Cholamandalam MS General Insurance Company Limited
Chola MS HELP – Health Claims Department
Shaw Wallace Building, Old No.154, New No.319, 2nd Floor
Thambu chetty Street, Parrys corner, Chennai 600 001
Customer Care Toll Free No: 1800-208-5544

V. 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

21. Authority to Obtain Records

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

22. Delay in intimation of claim

It is essential and imperative that any loss or claim under the policy has to be intimated to us strictly as per the policy conditions to enable us to appoint investigator for loss assessment. This will enable us to render prompt service by way of quick and fair settlement of claim, which is our primary motto. Any genuine delay, beyond Your control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Your end and especially if the delay has hindered conducting investigation on time to make proper assessment, to mitigate further loss, if any may not only delay the claim settlement but also may result in claim getting rejected on merits.

23. 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

IV.CONDITIONS FOR RENEWAL OF THE CONTRACT

24. 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.

25. Possibility of Revision of Terms of the policy including the Premium Rates:

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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.

26. 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

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, at least 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. 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 you decide to increase the sum insured at the time of renewal, subject to our acceptance, then the coverage for the increased sum insured shall be as if a new policy is issued for the additional sum insured. The additional Sum Insured will be available subject to 30 day, 1 year and 4 years waiting periods as per exclusions 5.a.I , 5.a.II and 5.b above

29. 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:

Short Period Scales			
For 1 year policies	**For 2 year policies**	**For 3 year policies**	**Refund % of premium**
0 to 1 months	0 to 2 months	0 to 3 months	**72%**
1 to 2 months	2 to 4 months	3 to 6 months	**66%**
2 to 3 months	4 to 6 months	6 to 9 months	**59%**
3 to 4 months	6 to 8 months	9 to 12 months	**52%**
4 to 5 months	8 to 10 months	12 to 15 months	**45%**
5 to 6 months	10 to 12 months	15 to 18 months	**38%**
6 to 7 months	12 to 14 months	18 to 21 months	**30%**
7 to 8 months	14 to 16 months	21 to 24 months	**22%**
8 to 9 months	16 to 18 months	24 to 27 months	**14%**

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9 to 10 months	18 to 20 months	27 to 30 months	**5%**
> 10 months	> 20 months	> 30 months	**No Refund**

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.

30. Migration

The insured person will have the option to migrate the policy to other Topup 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 Topup 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

31. Arbitration

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

32. Automatic Termination

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

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

Section 7 Grievances

Mechanism for Grievance Redressal:-

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

Website : www.cholainsurance.com
Toll free : 1800 208 5544

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

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

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

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

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

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

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

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

AN N E X U R E 1 *(attached to and forming part of policy*
List of Non-Medical Expenses excluded in this Policy

LIST I – ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY	
Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICES CHARGES WHERE NURSING CHARGE ALSO CHARGED

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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

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65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU0DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
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

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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