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 9100, 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 FLEXI HEALTH SUPREME
Policy Wordings
CHOHLIP22225V012122

CHOLA FLEXI HEALTH SUPREME

POLICY SECTIONS

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

1. DEFINITIONS

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

A. STANDARD DEFINITIONS:

1. Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3. Cashless facility means a facility extended by the Insurer 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 Insurer to the extent pre-authorization approved.

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

5. 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.

6. Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

7. 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

8. 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

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

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

10. 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.

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

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

12. 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.

13. 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.

14. 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

15. Hospitalization 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.

16. Illnessmeans 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.

17. 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.

18. 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.

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19. 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 lifesupport facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

20. 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.

21. **Maternity** Expenses means;
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

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

23. 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.

24. 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.

25. 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.

26. 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.

27. 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.

28. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

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

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

31. 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.

32. 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.

33. Pre-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the Hospitalization 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.

34. 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

35. 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.

36. 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.

37. 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.

38. 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.

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

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40. 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

41. 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.

B. SPECIFIC EXCLUSIONS:
42. 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).

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

44. 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.

45. Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha, and Homeopathy in the Indian context.

46. Base Sum Insured means the Sum Insured as specified in the Policy Schedule against the respective base covers.

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

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

49. 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.

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

51. 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.

52. 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.

53. Family means only the family members / extended family members listed below, who is related to Primary Insured or proposer.

- Your legally married Spouse as long as he or she continues to be married to you
- Your natural or legally adopted Children.
- Your natural parents or parents that have legally adopted you
- Parents in Laws as long as your spouse continues to be married to you and
- Siblings

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

55. Identificationor **ID card** means the card issued to You by us.

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

57. 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.

58. 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.

59. 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.

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

a. The Expiry Date specified in the Policy Schedule
b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (7.a.7) below.

61. 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.

62. Policy Schedulemeans 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.

63. 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

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

65. 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.

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

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.

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2. PERSONS WHO CAN BE INSURED:

Persons who can be covered	Entry Age	Important Conditions
Age mentioned below refers to completed age at the commencement date of this policy		
Self, Spouse, Parents, Parents-in-law	Minimum – 18 years Maximum – 75 Years	- The Proposer should be minimum 18 years on the Commencement date of the policy.
Children upto 4	Minimum – 03 Months Maximum – 26 Years	- Children between 03 months to 18 years can be insured provided either parent is getting insured under this policy. - Maximum Renewal age for children is 26 years. On renewal after completion of 26 years, such Insured Person will have the option to migrate to any separate health insurance policy, with continuity benefits. - Female married Children of the proposer are not eligible for coverage under the policy
Siblings	Minimum – 05 Years Maximum – 75 Years	- Siblings between 05 to 18 years can be covered provided the proposer is covered under this policy. - Female married sibling of the proposer is not eligible for coverage under the policy
Type of Sum Insured (SI) Options *(Coverage of Self/Proposer is mandatory under Family Floater and is not mandatory under Individual Cover)*		
Type of Sum Insured options	**Family members eligible for cover**	**Important Conditions**
Individual Sum Insured Basis	Self, Spouse, Children upto 4, Parents, Parents in Laws and Siblings	- Each covered person will have an independent Sum Insured limit within the same policy.
Floater Sum Insured Basis	Self, Spouse and Children upto a maximum of 6 members	- Single Sum insured floats among the family members covered under the policy.
Policy Tenure options	1 or 2 or 3 years	---discount on 2 year policy and ---discount on 3 year policy with Single premium payment option only.
Premium payment options	Single premium payment or Annual or Half-Yearly or Quarterly or Monthly mode.	- The premium payment mode opted shall be as mentioned in the policy schedule

3. SCHEDULE OF BENEFITS:

This policy will cover all the Insured Persons under the policy upto the limits stated in the policy Schedule. The insurance cover is subject to terms, conditions and exclusions of this policy.

Plan	Basic	Plus	Premiere
Sum Insured (SI) in (Rs.) Options	Rs. 50,000/-, 1/2/3/5/7.5/10/15/20/25 Lakhs	Rs. 5/7.5/10/15/20/25 Lakhs	Rs.30/40/50/75 Lakhs, Rs.1/2/2.5/3/5 Crores
Basic Covers			
Hospitalization Expenses	Covered upto sum Insured		

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Plan	Basic	Plus	Premiere
Pre-Hospitalization Expenses	Upto 30 days	upto 60 days	upto 60 days
Post-Hospitalization Expenses	Upto 60 days	upto 90 days	upto 120 days
Day Care Procedures	Covered upto sum Insured		
AYUSH Coverage	Covered upto sum Insured		
Domiciliary Hospitalization Cover	Covered upto sum Insured		
Organ Donor Hospitalization Expenses	Covered upto sum Insured		
Emergency Ambulance Expenses	upto 1% of SI subject to a maximum of Rs.2,000/- per hospitalization		upto 1% of SI subject to a maximum of Rs.5,000/- per hospitalization
New born Baby Cover	Coverage from Day one, provided mother is covered for a continuous period of 12 months	Covered under Maternity	
Additional Benefits			
Sum Insured Restoration	Automatic Sum Insured Restoration in the event of exhaustion or insufficient Base Sum Insured & Cumulative Bonus. (Applicable for SI of Rs.3 Lakhs and above under Basic Plan)		
Additional Sum Insured for claims due to Road Traffic Accident (RTA)	Upto 25% of SI subject to a maximum Rs.3 lakhs once during the policy Year.(Applicable for SI of Rs.3 Lakhs and above under Basic Plan)		upto a maximum Rs.5 lakhs once during the policy year.
Daily Care Benefit	Rs.500/- per day/ maximum of 10 days per policy year.		Rs.1000/- per day/ maximum of 10 days per policy year.
Compassionate Travel	Reimbursement of Air travel expenses upto maximum Rs.5000/- per policy year (per annum in case of multi-year tenure)		Reimbursement of Air travel expenses upto maximum Rs.25000/- per policy year (per annum in case of multi-year tenure)
Repatriation of Mortal Remains	Reimbursement upto Rs.3,000/- subject to an admissible claim under the policy		Reimbursement upto Rs.10,000/- subject to an admissible claim under the policy
Specialist Consultation Charges	Reimbursement of the cost of obtaining Specialist Medical Opinion upto maximum of Rs.25,000/-		Reimbursement of the cost of obtaining Specialist Medical Opinion upto maximum of Rs.50,000/-
Global Hospitalization Cover	Not Covered	Reimbursement of In-patient hospitalization / Day Care Expenses incurred outside India upto Base SI. Diagnosis has to be within India	
Personal Accident (PA) Cover	Not Covered	Sum Insured options – equal to Health SI upto a maximum of Rs. 50L	
Child Education Benefit	Not Covered	Fixed benefit of Rs.25,000/- to dependent children, subject to admissible claim under Personal	Fixed benefit of Rs.50,000/- to dependent children, subject to admissible claim under Personal

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Plan	Basic	Plus	Premiere
		Accident cover. This will be a fixed one time benefit irrespective of the no. of Children during the entire lifetime of the policy with Us.	Accident cover. This will be a fixed one time benefit irrespective of the no. of Children during the entire lifetime of the policy with Us
Consumables cover	Not Covered	Reimbursement of expenses of list of 'Items for which coverage is not available in the policy', subject to an admissible In-Patient hospitalization claim	
Home Care Expenses	Not Covered	Reimbursement of Medical Expenses upto Rs.3000/- per day towards treatment of listed illness upto a maximum of 15 days per policy year	Reimbursement of Medical Expenses upto Rs.5000/- per day towards treatment of listed illness upto a maximum of 15 days per policy year
Vaccination Charges	Not Covered	Reimbursement of Vaccination charges upto Rs.5000/- for the new born baby covered under the policy upto one year of age.	
Maternity Cover	Not Covered	Reimbursement upto Rs.50,000/- per delivery after a waiting period of 36 months. Coverage for New Born Baby	Reimbursement upto Rs.1 Lakh per delivery after a waiting period of 36 months. Coverage for New Born Baby
Infertility Treatment	Not Covered	Not Covered	Reimbursement upto Rs.2,00,000/-
Bariatric Surgery	Not Covered	Not Covered	Reimbursement upto Rs.5 Lakhs
Recovery Benefit	Not Covered	Not Covered	Lumpsum Benefit equal to .5% of Base SI, for continuous hospitalization of more than 10 days subject to an admissible claim under Basic In-patient hospitalization expenses
Specs/ Contact lens/hearing aids	Not Covered	Not Covered	Reimbursement of expenses upto Rs.10,000/- per policy year after 24 months of continuous cover
High End Diagnostics	Not Covered	Not Covered	Reimbursement of expenses incurred on OPD basis for High End Diagnostics listed in the policy upto a max. of Rs.25,000/- per policy year
Emergency Air Ambulance Cover	Not Covered	Not Covered	Reimbursement of expenses for emergency Air Ambulance upto Rs.5 Lakhs per policy year
Sublimit			
Room Rent	Upto Rs.2000/- per day for Sum Insured Rs.50,000/-, Rs.1 Lakh	No limits applicable	

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Plan	Basic	Plus	Premiere
	& Rs. 2 Lakhs. No Room limit for Sum Insured above Rs.2 Lakhs		
Waiting Periods			
30 Days Waiting Period	Applicable	Applicable	Applicable
2 Yrs. Waiting Period for listed illness	Applicable	Applicable	Applicable
Pre-existing Disease	3 Years	3 Years	2 Years
Renewal Benefits			
Cumulative Bonus	10% - 50%	50%-100%	50% - 100%
Health Checkup	Once in two claim free years upto defined limits		Once in two years irrespective of claim status, upto defined limits
Wellness	Not Covered	Covered	Covered

- The benefit applicable to the insured under the policy will depend on the Plan and Sum Insured opted and as mentioned in the Policy Schedule.
- In relation to individual Sum Insured 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, unless otherwise specified and
- In relation to a Family Floater Sum Insured, it is our maximum liability for any and all claims made by You and all of Your Insured Family members during the Annual Period (i.e. per annum for multi-year tenure) within the Policy period, unless otherwise specified.

4. POLICY COVERAGE:
Upon the happening of the events listed under sections 4.1 and 4.2 below during the policy period, the policy will pay the benefits as detailed below, up to the limits defined in the Schedule of Benefits / Policy Schedule and as per the General Conditions in Section 7 of this policy.

4.1. BASIC COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
4.1.1 **In Patient Hospitalization Expenses**	This Policy will indemnify the Reasonable and Customary 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** subject to terms, conditions and exclusions mentioned in the Policy. a. Room, Boarding charges, ICU charges as provided by the Hospital/Nursing Home b. Nursing Expenses incurred during In-Patient Hospitalization c. Surgeon, Anesthetist, Medical Practitioner, Consultants & Specialist Fees d. Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, and diagnostic tests)	**Specific Condition:** For Sum Insured Rs.50,000/-, Rs. 1 Lakh and 2Lakhs, the maximum room rent allowed is Rs.2000/-per day.

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4.1. BASIC COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	e. Anesthesia, 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.	
4.1.2 **Pre Hospitalization Expenses**	This Policy will pay for medical expenses incurred upto the number of days as mentioned in the Schedule of benefits prior to the date of **Hospitalization** provided that a. The expenses were incurred after the first 30 day waiting period as mentioned in Waiting period section 5.a.iii 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	**Specific Condition:** Payment under this benefit will reduce the Base Sum Insured.
4.1.3 **Post Hospitalization Expenses**	This Policy will pay for medical expenses incurred upto the number of days as mentioned in the Schedule of benefits 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 Hospitalisation** was required, and b. The Inpatient **Hospitalisation** claim for such Hospitalisation is admissible by Us	**Specific Condition:** Payment under this benefit will reduce the Base Sum Insured.
4.1.4 **Day Care Procedures**	This Policy will pay Reasonable and Customary Medical Expenses incurred as a Day Care Procedure/Treatment for any disease/illness/injury that requires less than 24 hours of Hospitalization because of technological advancement, upto **Sum Insured** stated in the **policy schedule,** during the policy period if it is performed in a network hospital. In case the procedure is performed in a non-network hospital, the same must be pre-authorized by us. Treatment normally taken on an out-patient basis is not included in the scope of cover	**Specific Condition:** Pre-authorization 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. Payment under this benefit will reduce the Base Sum Insured.
4.1.5 **AYUSH Coverage**	This policy will pay Reasonable and Customary charges incurred for Hospitalization expenses that require more than 24 hours of Hospitalization for illness or accidental bodily injury for non-allopathic treatments given under Ayurveda, Unani, Siddha and Homeopathy systems upto Sum insured	**Definition of AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH medical practitioner(s) comprising of any of the following:

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4.1. BASIC COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	stated in the policy schedule. The treatment should have been undergone in AYUSH Hospital. Payment under this benefit will reduce the Base Sum Insured.	a. Central or State Government AYUSH Hospital; or b. Teaching hospital attached to AYUSH college recognised by 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.
4.1.6 **Domiciliary Hospitalisation**	This policy will reimburse the Reasonable land Customary Medical Expenses incurred by an **Insured Person** for medical treatment taken at his/her home which would otherwise have required Hospitalization provided: a) on the advice of the attending Medical Practitioner, the **Insured Person** could not be transferred to a Hospital or b) a Hospital bed was unavailable, and provided that: I. The condition for which the medical treatment is required continues for at least 3 days, in which case the Policy pays reasonable cost of necessary medical treatment for the entire period II. Pre-hospitalisation and Post hospitalisation expenses will be covered under this benefit in accordance with Section 4.1.2and 4.1.3 respectively. Cashless facility will not be available for such a claim. Payment under this benefit will reduce the Base Sum Insured.	**Specific Exclusion:** 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.
4.1.7 **Organ Donor**	This policy will pay for medical expenses incurred on a legal Organ Donor's treatment for the harvesting of the organ donated. We will not pay for Donor's pre and post	**Specific Condition:** Payment under this benefit will reduce the Base Sum Insured.

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4.1. BASIC COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
Hospitalization Expenses	Hospitalization expenses or any other medical treatment consequent to the harvesting.	
4.1.8 **Emergency Ambulance Expenses**	This policy 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 section 3.1.1 above.	**Specific Condition:** Payment under this benefit will reduce the Base Sum Insured.
4.1.9 **New Born Baby Cover**	This policy will pay for the Inpatient hospitalization medical expenses incurred for the New Born Baby from Day one till policy expiry date mentioned in the policy schedule subject to a limit of 10% of Sum Insured subject to a maximum of Rs.50,000/- whichever is less within Mother's Sum Insured provided that 1. The mother is covered under the policy for a period of 12 months continuously without break. 2. Intimation about the birth of the New Born Baby is given to us and the baby is included and endorsed under the policy for the cover to commence. 3. Routine Vaccinations for the baby are not admissible under this cover. 4. 30 days waiting period shall not apply for the New Born Baby cover 5. All other terms, conditions and exclusions shall apply for the New Born Baby cover.	**Specific Condition:** In case of Family Floater, the floater Sum Insured will be considered upto the limits stated above for New Born Baby cover. Payment under this benefit will reduce the Base Sum Insured.

The total amount payable under the policy, per year for all sections under 4.1 as above put together shall not exceed the Base sum insured shown in the policy schedule.

4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
4.2.1 **Sum Insured Restoration**	This policy will provide for automatic restoration of Base Sum Insured during the policy year, provided that: a. The Base Sum Insured and earned Cumulative Bonus is insufficient or exhausted as a result of payment of claims during the policy year. b. The maximum liability under a single claim under this benefit shall not be more than Base Sum Insured:	**Specific Conditions:** a. 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. b. Such restoration of Sum Insured will be available to each insured in case of an individual Sum Insured. If

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<table>
<tr><td colspan="2">4.2 ADDITIONAL COVERS</td><td></td></tr>
<tr><td>Benefits</td><td>Coverage</td><td>Specific Conditions / Exclusions / Definitions</td></tr>
<tr><td></td><td>c. The order of utilisation of the benefit will be as follows:
1. Base Sum Insured followed by;
2. Earned Cumulative Bonus (if any) followed by;
3. Sum Insured restoration

d. The Restored Sum Insured will be available subsequent to the first paid claim under basic Inpatient Hospitalisation Expenses cover.

Benefit Illustration under the cover is as below:

<table>
<tr><td colspan="5">Claim Scenario 1</td></tr>
<tr><td colspan="2">Sum Insured (SI) – Rs.3 Lakhs</td><td colspan="3">Cumulative Bonus (CB) – Rs.1.5 Lakhs</td></tr>
<tr><td>Claim No.</td><td>Claim Amount</td><td>SI</td><td>CB</td><td>Restoration of Base SI</td></tr>
<tr><td>1</td><td>Rs.3.5L</td><td>Rs.3L</td><td>Rs.50,000/-</td><td>-</td></tr>
<tr><td>2</td><td>Rs.2.5L</td><td>-</td><td>Rs.1L</td><td>Rs.1.5L</td></tr>
<tr><td>3</td><td>Rs.4.5L</td><td>-</td><td>-</td><td>Rs.3L (Restoration upto Base SI)</td></tr>
<tr><td colspan="5">Claim Scenario 2</td></tr>
<tr><td colspan="2">Sum Insured – Rs.3 Lakhs</td><td colspan="3">Cumulative Bonus –NIL</td></tr>
<tr><td>Claim No.</td><td>Claim Amount</td><td>SI</td><td>CB</td><td>Restoration of Base SI</td></tr>
<tr><td>1</td><td>Rs.4.5L</td><td>Rs.3L</td><td>-</td><td>Not applicable for first claim</td></tr>
<tr><td>2</td><td>Rs.3.5L</td><td>-</td><td>-</td><td>Rs.3L (Restoration upto Base SI)</td></tr>
</table>
</td><td>the Policy is issued on a floater basis, the Restored Sum Insured will be available on a floater basis.

c. All Claims under this benefit can be made as per the process defined under Section 7.27.a.

d. Sum Insured Restoration benefit will not be applicable for any claims arising out of Road Traffic Accident.

e. This cover shall be applicable for Sum Insured of Rs.3 Lakhs and above under Basic Plan.</td></tr>
<tr><td>4.2.2 Additional Sum Insured for claims due to Road Traffic</td><td>In the event of Inpatient Hospitalization of the insured due to an Accident, the basic sum insured shall be increased upto the limit as mentioned in the schedule of benefits provided that:</td><td>Specific Condition:
The unutilized amount under this benefit cannot be carried forward.

This cover shall be applicable for Sum Insured of Rs.3 Lakhs and above under Basic Plan.</td></tr>
</table>

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4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
Accident (RTA)	• The additional Sum Insured will be available on exhaustion of the Basic Sum Insured and Cumulative Bonus under the policy. • This cover will be available only once during the policy year and can be utilized only for that particular hospitalisation due to RTA. • Sum Insured Restoration will not be applicable for this benefit.	
4.2.3 **Daily Care Benefit**	This policy will pay daily cash benefit as mentioned in the Schedule of benefits towards accompanying person expenses, for each and every completed 24 hours of hospitalisation up to a maximum of 10 days per policy year. Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.	**Specific Condition:** For a claim to be admissible under this benefit, we should have accepted an inpatient Hospitalisation claim under the policy. This benefit shall not be payable for claims admitted under Home Care Expenses cover.
4.2.4 **Compassionate Visit**	In the event of the hospitalization 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 mentioned in the Schedule of Benefits for one of the immediate family member to travel to the hospital, provided the claim for Hospitalization is admissible under the policy. The benefit amount mentioned in the Schedule of Benefits will be 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). For the purpose of this cover, General exclusion no.6.B.19 shall stand deleted	**Definitions for the purpose of this cover,** **Life Threatening Medical Emergency** means a medical condition potentially fatal which could result in death of the life of the **Insured.** Immediate **family member** shall mean and include the **Insured Person's** Spouse, children (including adopted and step children) and parents. **Specific Conditions:** The scope of this cover is within the boundaries of India. This benefit will be available only on reimbursement basis. Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.
4.2.5 **Repatriation of Mortal Remains**	This policy will reimburse the actual expenses subject to the maximum limit mentioned in the Schedule of Benefits incurred for transportation of mortal remains of the Insured Person from the hospital to the residence and/or cremation	**Specific Conditions:** This benefit will be available only on reimbursement basis.

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Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	and/or burial ground subject to an admissible claim under basic Inpatient Hospitalization cover.	Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.
4.2.6 **Specialist Consultation Charges**	This policy will reimburse the cost of obtaining Medical Opinion from a Specialist Medical Practitioner for illness or injury upto a maximum limit as mentioned in the Schedule of Benefits subject to an admissible claim under basic Inpatient Hospitalization cover. This will not cover cost of additional tests, diagnostic reports etc. This can be availed once in a policy period (per annum in case of multi-year tenure).	**Specific Conditions:** In the case of Family floater policy, the benefit mentioned in the Schedule of Benefits will represent our maximum liability for any and all claims made by Insured person(s) during the policy period. Cashless facility will not be available for such a claim. Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.
4.2.7 **Global Hospitalization cover**	This Policy will indemnify the Reasonable and customary, medically necessary expenses as listed under Inpatient hospitalization cover, incurred outside India and anywhere across the World on the advice of the Medical Practitioner, during the policy period upto a maximum of the Base Sum Insured subject to a. The diagnosis was made in India b. Medical expenses payable under this cover shall be limited to 4.1.1 In-patient Hospitalization Expenses and 4.1.4 Day care Expenses c. Pre-hospitalisation and Post hospitalisation expenses shall not be payable under the cover. d. Only Base Sum Insured and Cumulative Bonus will be applicable for this cover. e. Sum Insured Restoration shall not be applicable for Global Hospitalisation Cover f. This benefit will be available only on reimbursement basis. This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	**Specific Condition:** a. Claim payment under this cover will be based on the rate of exchange as on the Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of claims. If on the Insured Person's Date of Loss, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion. b. Claim payment under this cover shall form part of the Base sum insured and will impact Cumulative Bonus.
4.2.8 **Personal Accident (PA) Cover**	This policy will pay a Fixed benefit equal to 100% of the Basic Health Sum Insured or Rs. 50 Lakhs, whichever is lower, on the death of the insured person, directly due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. In addition to Personal Accident Sum Insured, the Policy will also pay the cost incurred towards transporting the mortal	**Specific Condition:** 1. This policy shall automatically terminate upon the Insured Person's death or payment of 100% of Sum Insured under Personal Accident Cover. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. 2. The Personal Accident cover shall be applicable to all Insured members on individual basis under

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Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	remains from the place of death to the hospital and/or residence and/or cremation and/or burial ground upto a maximum of Rs.5,000/-. This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.	Individual Sum Insured option. On Family floater basis, the Personal Accident shall be applicable only for SELF covered under the policy. **Territorial limits**: Worldwide Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.
4.2.9 **Child Education Benefit**	This policy will pay a one-time Education benefit as mentioned in the Schedule of Benefits to the dependent children, following an admissible Death claim of the Insured Person under the Personal Accident section of the policy, provided that, a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution. b. Age of the child or children as the case shall not be more than 25 completed years c. This would be a onetime Lumpsum payment during the entire policy tenure with the Insurer, irrespective of the number of children. d. Deceased Insured should be an earning parent This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	**Specific Condition:** The claim payable under this cover shall be over and above the benefit payable under Personal Accident section and Base Sum Insured.
4.2.10 **Consumables cover**	This policy will indemnify the Reasonable and Customary expenses incurred towards purchase of items listed under 'Annexure 1 – List 1 – Items for which coverage is not available in the policy' during hospitalization, subject to an admissible In-Patient Hospitalization or Day Care treatment claim under the policy during the policy period. For the purpose of this cover, General exclusion no. 6.b.30 shall stand deleted Claim payment under this cover shall form part of the Base sum insured and will impact Cumulative Bonus This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy	**Specific Exclusion:** The following items shall be excluded from scope of this coverage: 1. Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage. 2. External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipments. 3. Any item which is neither medical consumable nor medically necessary nor prescribed by Doctor

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4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
4.2.11 **Home Care Expenses**	This policy will reimburse the reasonable and customary medical expenses upto the daily limits mentioned in the schedule of benefits, per day towards Homecare Treatment for the following medical conditions, during the Policy Period upto a maximum of 15 days per policy year, subject to the specific conditions applicable for the cover. 1. Gastroenteritis 2. Chemotherapy 3. Pancreatitis 4. Dengue 5. Chronic obstructive pulmonary disease management 6. Hepatitis 7. COVID-19 Sum Insured Restoration shall not be applicable for Home care Treatment Claim payment under this cover shall form part of the Base sum insured and will impact Cumulative Bonus. This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy. **Specific Definition:** **Homecare Treatment** means treatment availed by the Insured Person at home which in normal course would require care and treatment at a hospital but is actually taken at home provided that: a) The Medical Practitioner advices the Insured Person in writing to undergo treatment at home. b) There is continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained	**Specific Conditions:** a. The treatment in normal course would require care and In-patient treatment at a hospital but is actually taken at home, provided that: i. The Medical Practitioner advices the Insured person in writing to undergo treatment at home ii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment. iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained. iv. This cover shall reimburse the following medical expenses incurred during Home care treatment subject to the terms, conditions, waiting periods and exclusions applicable under the policy,. a. Diagnostic tests undergone at home or at diagnostics centre as prescribed by the Medical practitioner b. Medicines prescribed in writing c. Consultation charges of the medical practitioner d. Nursing charges related to medical staff e. Medical procedures limited to parenteral administration of medicines f. Consumables as listed in Annexure 1 of this cover b. Pre-hospitalisation and Post hospitalisation expenses shall not be payable under this cover. c. Claim under this cover shall be on Reimbursement basis.
4.2.12 **Vaccination Charges**	This policy will reimburse the Reasonable and Customary charges incurred towards Vaccination charges for the New Born Baby during the policy period, as per the National Immunization Scheme (India) listed in the policy, till the	<table><tr><th>Time Interval</th><th>Vaccinations to be done (Age)</th><th>Frequency</th></tr><tr><td>**0 – 3 Months**</td><td>BCG (Birth to 2 Weeks) OPV (0,6,10 weeks) OR</td><td>1</td></tr></table>

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<table>
<tr><th colspan="2">4.2 ADDITIONAL COVERS</th><th></th></tr>
<tr><th>Benefits</th><th>Coverage</th><th>Specific Conditions / Exclusions / Definitions</th></tr>
<tr><td></td><td>baby completes 1 year (12 months) upto the limits mentioned in the Schedule of Benefits, subject to
1. An admissible claim under Maternity cover of the policy
2. Intimation about the birth of the New Born Baby is given to us and the baby is included and endorsed under the policy for the cover to commence.
3. 30 days waiting period shall not apply for the New Born Baby cover
4. Sum Insured Restoration shall not be applicable for this cover
5. We will continue to provide Reasonable and Customary charges for vaccination of the New Born Baby until the baby completes 12 months, if the Policy ends before the New Born Baby has completed one year subject however to the Policy being renewed in the subsequent year.
6. Any Expenses related to the doctor, nurse or any incidental expenses are not payable.

For the purpose of this cover, General exclusion no.6.b.21 shall stand deleted

Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.

This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.</td><td>
<table>
<tr><td rowspan="4"></td><td>OPV + IPV1 (6,10 weeks)</td><td>3 or 4</td></tr>
<tr><td>DPT (6 & 10 week)</td><td>2</td></tr>
<tr><td>Hepatitis-B (0 & 6 week)</td><td>2</td></tr>
<tr><td>Hib (6 & 10 week)</td><td>2</td></tr>
<tr><td rowspan="4">3 – 6 Months</td><td>OPV (14 week) OR OPV + IPV2</td><td>1 or 2</td></tr>
<tr><td>DPT (14 week)</td><td>1</td></tr>
<tr><td>Hepatitis-B (14 week)</td><td>1</td></tr>
<tr><td>Hib (14 week)</td><td>1</td></tr>
<tr><td>9 Months</td><td>Measles (+9 months)</td><td>1</td></tr>
<tr><td>12 Months</td><td>Chicken Pox (12 months)</td><td>1</td></tr>
</table>
</td></tr>
<tr><td>4.2.13 Maternity Cover</td><td>This policy will reimburse the Reasonable and Customary 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 first two deliveries or termination or either one of each during the lifetime of the Insured, subject to a waiting period of 3 continuous years of coverage under this policy, subject to IRDAI portability guidelines.

For the purpose of this cover, General exclusion no.6.a.15-Maternity: Code – Excl18, shall stand deleted

Newborn Baby Cover:</td><td>Specific Exclusion applicable to Maternity:
Following Expenses shall be excluded from the scope of this coverage:
• Ectopic pregnancy (although it shall be covered under section Basic Inpatient Hospitalisation).
• Expenses incurred for pre/post natal care
• Pre/Post hospitalization benefit (Base Cover 4.1.2 and 4.1.3)

Specific condition applicable to Newborn Baby Cover:
The new born baby will be covered within the Sum Insured of the mother in case the policy is on Individual Sum Insured basis. In case of family floater policy, the floater sum insured will be the maximum limit for this benefit.</td></tr>
</table>

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4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	This policy will also pay for the Hospitalization expenses incurred for a new born baby, from the day of birth to 90 days, subject to 1. a valid claim under maternity expenses for an insured mother 2. routine Vaccinations for the baby are not admissible under this cover. 3. 30 days waiting period shall not apply for the New Born Baby cover 4. All other terms, conditions and exclusions shall apply for the New Born Baby cover Sum Insured Restoration shall not be applicable for Maternity and New Born Baby Cover Claim payment under this cover shall form part of the Base sum insured and will impact Cumulative Bonus. This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	
4.2.14 **Infertility Treatment**	This Policy will indemnify the Reasonable and Customary medically necessary treatment expenses incurred on the advice of the Medical Practitioner for treatment of Infertility / Subfertility including but not limited to IVF, IUI, ZIFT, ICSI upto the maximum limit mentioned in the schedule of benefits during the policy period, subject to a. A waiting period of 24 months from the date of first inception of this policy with Us, provided that the policy has been renewed continuously with this cover since inception, without a break b. For the purpose of claiming under this benefit, either in-patient hospitalisation or Day care procedure/treatment is mandatory. c. Sum Insured Restoration shall not be applicable for Infertility treatment d. Claim under this benefit shall be payable only upto the limit mentioned in the Schedule of Benefits during the entire lifetime of the policy with Us. e. Infertility treatment benefit shall be available only to female insured members under the policy.	**Special Exclusions applicable to Infertility Treatment** The Company shall not be liable to make any payment under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of: 1. Pre and Post treatment expenses 2. Sub-fertility services that are deemed to be unproven, experimental or investigational 3. Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided. 4. Reversal of voluntary sterilization 5. Treatment undergone for second or subsequent pregnancies except where the child from the first delivery/ previous deliveries is/are not alive at the time of treatment 6. Payment for services rendered to a surrogate 7. Costs associated with cryopreservation and storage of sperm, eggs and embryos

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4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	For the purpose of this cover, General exclusion no.6.a.14.ii shall stand deleted Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus. This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	8. Selective termination of an embryo. 9. Services done at unrecognized centre 10. Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures
4.2.15 **Bariatric Surgery**	This policy will indemnify the Reasonable and Customary medical expenses as listed under Inpatient hospitalization expenses, incurred by the Insured Person for undergoing Bariatric Surgery on Inpatient basis, during the policy period upto the maximum limit mentioned in the Schedule of Benefits, subject to the following: i. Surgery to be conducted is upon the advice of the Doctor ii. The member has to be 18 years of age or older and iii. Body Mass Index (BMI) greater than or equal to 40 iv. BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss: a. Obesity-related cardiomyopathy b. Coronary heart disease c. Severe sleep apnea d. Uncontrolled Type2 Diabetes v. Sum Insured Restoration shall not be applicable for Bariatric Surgery Cover vi. Pre-hospitalisation and Post hospitalisation expenses shall not be payable under this cover. For the purpose of this cover, General exclusion no.6.a.3 shall stand deleted This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	**Specific Condition:** Claim payment under this cover shall form part of the Base sum insured and will impact Cumulative Bonus.
4.2.16 **Recovery Benefit**	This policy will pay a lumpsum equal to 0.5% of Base Sum Insured, in the event of hospitalization of the Insured Person for a continuous period of more than 10 days subject to admissibility of claim under Basic In-Patient Hospitalization cover.	**Specific Condition:** This benefit shall not be payable in case of Domiciliary Hospitalisation, Infertility Treatment, Global Hospitalization Cover, Bariatric Surgery and Home Care Expenses.

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IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

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4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.
4.2.17 **Specs/ Contact lens/hearing aids**	This policy will reimburse the Reasonable and Customary cost incurred by the Insured, towards purchase of spectacles or contact lens or a hearing aid (excluding batteries) during the policy period, subject to a maximum limit as mentioned in the Schedule of benefits, provided that it should be prescribed by the Medical Practitioner. Sum Insured Restoration shall not be applicable for Specs/ Contact lens/hearing aids cover For the purpose of this cover, General exclusion no.6.b.25 shall stand deleted Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus. This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	**Specific Condition:** 1. A waiting period of 24 months from the date of first inception of this policy with Us is applicable for availing the benefit under this cover, provided that the policy has been renewed continuously with this cover since inception, without a break 2. This benefit cannot be carried forward if unutilized in the eligible policy year. Cashless facility will not be available for such a claim.
4.2.18 **High End Diagnostics**	This policy will indemnify the reasonable charges incurred for the following diagnostic tests only on OPD basis during the policy period, if required as part of a medically necessary treatment subject to the maximum limit mentioned in the Schedule of Benefits: 1. Brain Perfusion imaging 2. Computed Tomography (CT) guided Biopsy 3. Computed Tomography (CT) Urography 4. Digital Subtraction Angiography (DSA) 5. Liver Biopsy 6. Magnetic Resonance Cholangiography Scan 7. Positron Emission Tomography– Computed Tomography (PET/CT) 8. Positron emission tomography – Magnetic Resonance Imaging (PET/MRI) 9. Renogram Sum Insured Restoration shall not be applicable for High End Diagnostics cover	**Specific Condition:** Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.

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4.2 ADDITIONAL COVERS		
Benefits	**Coverage**	**Specific Conditions / Exclusions / Definitions**
	This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	
4.2.19 **Emergency Air Ambulance Cover**	This policy will indemnify for ambulance transportation of the Insured in an airplane or helicopter subject to the maximum limit mentioned in the Schedule of Benefits for emergency life threatening health condition which require immediate and rapid ambulance transportation to the hospital / medical centre within India, for further medical management subject to an admissible claim under Basic In-Patient hospitalization Expenses. This Cover is otherwise subject to terms, conditions, limitations and exclusions mentioned in the Policy.	**Specific Condition:** The Medical Evacuation should be prescribed by a Medical Practitioner and should be Medically Necessary. Cashless facility will not be available for such a claim. Claim payment under this cover does not form part of the Base sum insured and will not impact Cumulative Bonus.

4.3 RENEWAL BENEFITS	
4.3.1 **Cumulative Bonus**	If the insured has not made a claim in a policy year (per annum in case of multi-year tenure) and has renewed the policy with us without a break, we will increase the Sum Insured under each subsequent policy by a percentage of the expiring policy Sum Insured as mentioned in the schedule of benefits. The maximum cumulative bonus shall at no time exceed 50% under Basic Plan and 100% under Plus and Premiere Plans of the policy Sum Insured. In the case of Individual Sum Insured, the cumulative bonus will be applicable to all family members who have not made a claim during the expiring policy year. In the case of a floater Sum Insured, cumulative bonus will be applicable only if none of the family members have made a claim under the previous policy year. In case of Multi year tenure, any increase in the cumulative bonus will be determined at the start of every new policy year and the same will be reflected on the policy schedule only at the time of renewal of the policy.
4.3.2 **Reduction in Cumulative Bonus**	In the event of a claim during a policy year (per annum in case of multi-year tenure), the claim free bonus in any subsequently renewed policies shall be reduced by a percentage as mentioned in the Schedule of Benefits. Such a reduction of cumulative bonus will not reduce the Sum Insured under the policy. In case of multi-year tenure, any decrease in the cumulative bonus will be determined at the start of every new policy year and the same will be reflected on the policy schedule only at the time of renewal of the policy.
4.3.3 **Health Check-up**	All Insured Persons under this policy will be eligible for a Health Check-up upto the limits defined below after two continuous claim free policy years under Basic and Plus Plan and after a block of every two continuous years, irrespective of claim status under Premiere plan. In case of family floater policy,

i. All the members of a family floater policy are eligible for a Health Check-up.
ii. If any of the members have made a claim under this Policy, the health check-up benefit will not be offered under the policy for any members.
iii. The limits mentioned below will be the maximum amount payable for any one or all the Insured Persons towards the Health Checkup.

The medical check-up can be availed on reimbursement basis only. The Insured should submit the copy of the reports and original payment receipt within 30 days from the last date of undergoing the Health Check-Up.

Payment under this benefit does not form part of the Sum Insured and will not impact the Bonus.

Note: Payment of expenses towards cost of health checkup will not prejudice the company's right to deal with a claim in case of non-disclosure of material fact and / or Pre-Existing Diseases in terms of the policy.

Sum Insured	Benefit Limit
Rs.1 / 2 Lakhs	Rs.500/-
Rs.3 Lakhs	Rs.750/-
Rs.5 Lakhs	Rs.1000/-
Rs.7.5 / 10 Lakhs	Rs.2500/-
Rs.15 / 20 Lakhs	Rs.3000/-
Rs.25 Lakhs	Rs.3500/-
Rs.30 / 40 Lakhs	Rs.6000/-
Rs.50 / 75 Lakhs/ Rs.1 / 2 / 2.5 / 3 / 5 Crores	Rs.10,000/-

4.4 WELLNESS ADVANTAGE

Following Wellness Program shall be available only to Insured Persons from 18 years of age covered under the policy and as mentioned in the Schedule of Benefits. This program is intended to incentivize the Insured Person(s) for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services.

Insured has to download the Chola MS app on their mobile to avail the wellness program/services. The Mobile app will enable Insured to track and monitor their progress against your personal health related goals and definitive actions towards improving your health using the below features.

Health Assessment:
As a first step towards Good Health, Insured can do a regular analysis of his/her health status by answering to various questionnaire covering aspects like Diet, Body profile, lifestyle, Mental Wellness and Medical History. Based on the response Health score will be generated on Insured's present health status and also highlight various risks which one should worry about on developing any lifestyle related disease.
This would be shared in personalized detailed analysis report with Immunity Score, Health Goals & suggestive actions to the Insured.
Weekly SMS with snapshot of weekly activity shall be sent to the Insured, which will give Trend & comparison with last week activity and highlighting specific days on which the change is noticeable.

Digital Health Coaching:
i. Insured can enrol in the program basis specific goals in his /her mind from list of goals displayed on the screen of the application.

ii. If Insured wants to set his/her own program and wants to follow that, he/she can quickly add the program and track his daily goal.
iii. Once the program is activated, Insured can add his daily achieved goal in the various categories like exercise, calorie consumed, healthy habits just by clicking on 'Add button.

Medicines Delivery :
Home delivery of the Medicines prescribed by a Registered Medical Practitioner from the nearby Network Pharmacy, subject to copy of prescription being shared as applicable and availability of the medication with the Pharmacy. The cost of the medication will have to be borne by the Insured.

Preventive Health Checks & Diagnostic Tests from network Labs:
Insured can use the Booking module of the App to book appoints for Health checkup packages at discounted price. The cost of the diagnostics will have to be borne by the Insured.

Emergency helpline connect:
Registered Insured can avail the emergency helpline no. for booking ambulance services.

Terms and Conditions applicable to Wellness Advantage
1. Any Information provided by the Insured shall be kept confidential.
2. For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services.
3. All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Person may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilize the services will solely be at the discretion of the Insured Person.
4. We/Company/Us or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Person may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
5. This shall not be deemed to substitute the Insured Person's visit or consultation to an Independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
6. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

HEALTH DISCOUNT @ RENEWAL:

Insured Person from 18 years of age can avail discount on applicable Renewal Premium by accumulating Healthy Weeks as per table given below.

Criteria of Health Week	
One Healthy week (tracked through Insured's wearable device linked to the Chola MS Mobile App and Your Policy number)	Recording minimum 50,000 steps in a week subject to maximum 10,000 steps per day

Healthy Week Discounts	
No. of Healthy Weeks Accumulated	**Discount on Renewal Premium**

1 – 4	0.50%
5 – 8	1.00%
9 – 12	2.00%
13 – 16	3.00%
17 – 26	5.00%
27 – 36	7.50%
Above 36	10.00%

Steps to accumulate Healthy Weeks
Step 1 – Chola MS Mobile App must be downloaded on the mobile.
Step 2 - Start accumulating Healthy Weeks by tracking the step count through the Wearable device linked to Chola MS Mobile App and Your Policy number

Application of Healthy Week discount @ Renewal:

Annual Policy	• Discount amount accrued based on Number of accumulated Healthy Weeks during the expiring Policy Year will be applied on the Renewal Premium for expiring Policy Sum Insured and for Insured Person covered under expiring Policy
Multi Year Policy	• Healthy weeks discount earned on yearly basis will be accumulated till Policy End date. • On Renewal of the Policy, average of the Healthy weeks achieved will be considered to arrive at the discount % and will be applied on Renewal Premium of subsequent year and for Insured Person covered under expiring Policy.
Individual Sum Insured option	• Healthy weeks for each Insured Person will be tracked and accrued. • Discount % based on accumulated Healthy weeks will be applicable on Individual Renewal premium
Family Floater Sum Insured option	• Healthy weeks for each Insured Person will be tracked and accrued. • Each Insured Person from 18 years of age has to complete Healthy week to avail discount. • Healthy weeks achieved by each Individual Insured under floater policy will be considered on average basis to arrive at the discount percentage applicable on the renewal premium

Illustration on application of Healthy Weeks discount for a term of ONE Year:

Policy Period	Individual SI	Age of the Insured (in years)	Health Weeks Accumulated	Discount % on Renewal Premium	Illustrative Renewal Premium	Illustrative Renewal premium after Healthy Week Discount
Year 1	Insured 1	37	Not Applicable	Not Applicable	8500	Not Applicable
	Insured 2	33	Not Applicable	Not Applicable	7900	Not Applicable
	Insured 3	68	Not Applicable	Not Applicable	15500	Not Applicable
Year 2	Insured 1	38	6	1%	9200	9108
	Insured 2	34	3	0.50%	8800	8756
	Insured 3	69	8	1%	16950	16781
Year 3	Insured 1	39	10	2%	10800	10584

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	Insured 2	35	7	1%	9900	9801
	Insured 3	70	5	1%	18100	17919
Policy Period	**Floater SI**	**Age of the Insured (in years)**	**Health Weeks Accumulated**	**Discount % on Renewal Premium**	**Illustrative Renewal Premium**	**Illustrative Renewal premium after Healthy Week Discount**
Year 1	Insured 1	37	Not Applicable	Not Applicable	9800	Not Applicable
	Insured 2	33	Not Applicable			
	Insured 3	68	Not Applicable			
Year 2	Insured 1	38	6	5%	11500	10925
	Insured 2	34	3			
	Insured 3	69	8			
Year 3	Insured 1	39	6	NIL	13980	Discount Not Applicable
	Insured 2	35	-			
	Insured 3	70	8			

Illustration on application of Healthy Weeks discount for a term of THREE Years:

Individual SI	**Policy Year**	**Age of the Insured (in years)**	**Health Weeks Accumulated**	**Discount % on Renewal Premium**	**Illustrative Renewal Premium**	**Illustrative Renewal premium after Healthy Week Discount**
Insured 1	Year 1	37	2			
	Year 2	38	4			
	Year 3	39	3			
Total			9			
Average of 3 years for Insured 1			**3**	**0.50%**	**23400**	**23283**
Insured 2	Year 1	33	1			
	Year 2	34	2			
	Year 3	35	4			
Total			7			
Average of 3 years for Insured 2			**2**	**0.50%**	**18500**	**18408**
Insured 3	Year 1	68	1			
	Year 2	69	3			
	Year 3	70	1			
Total			5			
Average of 3 years for Insured 3			**1**	**0.50%**	**42000**	**41790**

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Floater SI	Policy Year	Age of the Insured (in years)	Health Weeks Accumulated	Discount % on Renewal Premium	Illustrative Renewal Premium	Illustrative Renewal premium after Healthy Week Discount
Insured 1	Year 1	37	2			
Insured 2		33	1			
Insured 3		68	1			
Insured 1	Year 2	38	6			
Insured 2		34	3			
Insured 3		69	8			
Insured 1	Year 3	39	6			
Insured 2		35	3			
Insured 3		70	8			
Total			38			
Average of 3 years for the family			**12**	**2.00%**	**19998**	**19598**

Specific Conditions:

- Premium will be discounted to the extent applicable to coverage corresponding to expiring Policy.
- In case of Increase in Sum Insured at Renewal, discount amount will be applied on the premium corresponding to expiring Policy Sum Insured.
- Healthy weeks discount @ Renewal will be applied only on Renewal of Policy with Us and only if accrued.
- We reserve the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation

5. WAITING PERIODS:

i. Pre-Existing Diseases – Code – Excl01:

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months under Basic and Plus plan and 24 months under Premiere plan, 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 36 months under Basic and Plus plan and 24 months under Premiere plan, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of first 24 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

Sl. No.	Organ / Organ System	Illness / Diagnosis / Surgeries / Procedures (irrespective of treatments medical or surgical)
1	Ear, Nose, Throat (ENT)	• Adenoids • Deviated Nasal Septum • Paranasal sinuses • Treatment of diseases on ears • Tonsils • ENT disorders & Surgery
2	Eye	• Cataract
3	Gynaecological	• Hysterectomy unless because of malignancy • Myomectomy • Dilatation and curettage (D&C)
4	Gastrointestinal	• All types of Hernia • Fissure • Fistula in Anus • Piles • Cirrhosis (however alcoholic cirrhosis is permanently excluded)
5	General (applicable to all organ systems/organs whether or not described above)	• Any type of benign Cyst/ Nodules/ Polyps/ Tumors/ Breast Lumps unless malignant
6	Others	• Congenital Internal Anomaly • Varicose Veins • Varicose Ulcers • Genetic Disorders
7	Orthopaedic	• Rheumatism and arthritis of any kind • Intervertebral Disc Prolapse, and Degenerative Disc / vertebral Disorders • Joint replacement Surgery unless because of accident • Spondylosis / Spondylitis and other Degenerative Disc Disorders • Ligament, Tendon and Meniscal tear
8	Urogenital	• Benign Prostatic Hypertrophy • Hydrocele • Stones in the Urinary and Biliary Systems

iii. 30-day waiting period – Code – Excl03

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

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

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

6. GENERAL EXCLUSIONS applicable to all sections of the policy:

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

A. <u>STANDARD EXCLUSIONS:</u>

1. Investigation & Evaluation – Code – Excl04:

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care – code – Excl05:

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

3. **Obesity/Weight Control: Code – Excl06**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

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. **Hazardous or Adventure sports:** Expenses related to any treatment, necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving. **Code – Excl09**
7. **Breach of law:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. **Code – Excl 10**
8. **Excluded Providers: Code-Excl11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible.

However, in case of life threatening situations following an accident, expenses upto the stage of stabilization are payable but not the complete claim.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Excl12**
10. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl13**
11. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. **Code – Excl14**
12. **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **Code – Excl15**
13. **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**
14. **Birth control, Sterility and Infertility: Code – Excl17**: Expenses related to Birth Control, 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 hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

B. <u>SPECIFIC EXCLUSIONS:</u>

16. War or any act of war, invasion, acts of foreign enemies, hostilities whether war be declared or not, civil war, revolution, insurrection, mutiny, martial law.
17. intentional self-injury or attempted suicide whether sane or insane.
18. 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.
19. Any travel or transportation costs or expenses excluding ambulance charges.
20. Circumcisions (unless necessitated by illness or injury and forming part of treatment).
21. Vaccination or inoculation unless forming a part of post-animal bite treatment.
22. Durable medical equipment (including but not limited to wheelchairs, crutches, artificial limbs and the like), (namely that equipment used externally from the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose; is generally not useful in the absence of an Illness or Injury and is usable outside of a Hospital) unless required for the treatment of Illness or Accidental Bodily Injury.
23. Any external congenital diseases, defects or anomalies.
24. Expenses incurred for any dental treatment or surgery of a corrective, cosmetic or aesthetic nature unless it requires hospitalisation and is carried out under general anaesthesia and is necessitated by Illness or Accidental Bodily Injury.
25. Any expenses incurred towards hearing aids, eyeglasses or contact lenses.
26. Independent personal comfort and convenience items or services which are non-medical in nature and are charged separately unless they form part of the room rent.

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27. 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.
28. Yoga and Naturopathy are excluded.
29. Claims arising out of the treatment / operation undertaken to cure impotence or to improve potency.
30. Non-medical Expenses incurred during Hospitalisation. The list of such Non-medical Expenses is placed at Annexure1.

C. SPECIFIC EXCLUSIONS APPLICABLE TO PERSONAL ACCIDENT COVER:

In addition to the General Exclusions listed in the Policy, this policy does not provide benefits for any death benefit attributable directly to the following:

1. Any **Pre-existing** condition or any complication arising from the same.
2. Any kind of murder which was caused by pre-meditated and dominant intention to kill the person. Any murder caused by an act which was originally unintended to kill the person does not fall under this exclusion
3. Any loss arising out of any kind of insect bite
4. Any loss directly resulting due to Pregnancy or childbirth or in consequence thereof.
5. war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all kings, princes, and people of whatsoever nation condition or quality.
6. Nuclear, Chemical and biological terrorism Exclusion Clause:
The Insurance under this Policy shall not extend to cover Death, disablement or injury resulting directly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.
For the purpose of this endorsement "Nuclear, chemical, biological terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.
"Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.
"Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.
7. The **Insured Person** 's participation in naval, military or air force operations whether in the form of military exercises or war games or actual engagement with the enemy with foreign or domestic;
8. any Injury sustained whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or travelling in any balloon or aircraft other than as a passenger (fare paying otherwise) in any duly licensed standard type of aircraft anywhere in the world;
9. any Injury sustained while the Insured is participating in contests of speed using a motorized vehicle or bicycle and/or hunting and/or skiing and/or skydiving and/or gliding and/or mountaineering and/or winter sports;
10. Resulting in injury whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs
11. Consequential losses of any kind or actual or alleged legal liability
12. Any Events/incidences that happened before the policy inception would not be covered. All events should fall under the policy duration.
13. While you are participating or training for any sport as a professional.
14. This Insurance does not cover any loss, damage, cost or expense directly arising out of or due to any **act of terrorism**. For the purpose of this Exclusion, an **act of terrorism** means an act, including but not limited to the use of force or violence and / or the threat

thereof, of any person whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purpose including the intention to influence any government and / or to put the public, or any section of the public in fear.

7. GENERAL CONDITIONS

A. STANDARD CONDITIONS:

1. Disclosure of Information:
The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policy holder.
(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).

2. 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.

3. 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 the 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 2o/o above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

4. 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.

5. Multiple policies

1. In case of multiple policies taken by an Insured during a period from the same or one or more insurers to indemnify treatment costs, the insured person shall have the right to require settlement of 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 if chosen by the policyholder 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.
2. Insured person having multiple policies shall also have the right to prefer claims under this policies for the amounts disallowed under any other policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle claim subject to the terms and conditions of this policy

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3. If the amount 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
4. Where the insured person has policies from more than one insurer to cover the same risk on an indemnity basis , the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Cancellation of cover

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.

1 Yr Policy Term		**2 Yrs Policy Term**		**3 Yrs Policy Term**	
Month	Premium Retained	Month	Premium Retained	Month	Premium Retained
1	8%	1	4%	1	3%
2	17%	2	8%	2	6%
3	25%	3	13%	3	8%
4	33%	4	17%	4	11%
5	42%	5	21%	5	14%
6	50%	6	25%	6	17%
7	58%	7	29%	7	19%
8	67%	8	33%	8	22%
9	75%	9	38%	9	25%
10	83%	10	42%	10	28%
11	92%	11	46%	11	31%
12	100%	12	50%	12	33%
		13	54%	13	36%

	14	58%	14	39%
	15	63%	15	42%
	16	67%	16	44%
	17	71%	17	47%
	18	75%	18	50%
	19	79%	19	53%
	20	83%	20	56%
	21	88%	21	58%
	22	92%	22	61%
	23	96%	23	64%
	24	100%	24	67%
			25	69%
			26	72%
			27	75%
			28	78%
			29	81%
			30	83%
			31	86%
			32	89%
			33	92%
			34	94%
			35	97%
			36	100%

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.

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.

8. 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

9. 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 Critical illness 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.

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

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience

11. Withdrawal of Policy:

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.

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.

12. 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.

13. Premium payment in Instalments:

If the insured person has opted for Payment of Premium on an instalment basis i.e. Annually, Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy).

i. Grace period of 15 days would be given to pay the instalment premium due for the policy
ii. During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the 'Waiting Periods', 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace period
iv. No interest will be charged if the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

14. 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.

15. Free Look Period:

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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 the 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 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

16. Nomination:
The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

B. SPECIFIC CONDITIONS:
17. Change of Address / Contact details
It is in the Insured person's interest to intimate us if there is any change in residential address and phone numbers.

18. Cost of Pre Policy Medical Check up (PPMC):

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

19. Premium Payment
a. Premium Payment Modes available under the policy:
The proposer shall have the following options to pay the premium:

1. Single Premium payment prior to commencement of cover or
2. Payment of premium on Annual, Half-Yearly, Quarterly and Monthly modes

This option shall be made at the time of proposing for insurance and the opted mode will be shown on the policy schedule.
Mode of Premium payment can be changed only at the time of renewal.

b. Specific Conditions applicable to other than single premium payment mode:

1. This mode is applicable for One, Two and Three year policy Terms.
2. In the event of proposer opting for other than single payment mode, the premium payable for the first 3 Months from the date of commencement of cover has to be paid upfront by way of Cheque/Direct Debit mode in favour of "Cholamandalam MS General Insurance Company Limited" and Debit Mandate to be submitted for the balance premium applicable for the policy period.

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3. The following conditions will apply in the event of claims under the policy (notwithstanding any terms contrary elsewhere in the policy):
   a. In case of any hospitalisation claim, an amount equivalent to the balance of the premium payable in the policy year (balance premium for the policy year in case of a long-term policy) would be recoverable from the admissible claim amount payable in respect of the Insured Person in case of Individual Policy or in respect of the family in case of Family floater policy.
   b. If the claim amount is less than the balance premium payable, then no claims will be payable till the applicable premium is recovered.

20. Underwriting Loading
Risk loading may be applied on premium payable (excluding taxes and cess) based on the details of the Insured Persons, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and results of the Pre-Policy medical check-up. The maximum risk loading for an individual shall not exceed 100%.

These loadings are applicable from commencement date of policy including subsequent renewal(s). A specific exclusion 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.

These loadings may only be applied if the proposal is accepted with the declared illness/ with the deviated value of medical test report, at the time of underwriting and only if the proposed policyholder accepts these loadings being applied for the underlying illness/condition at the time of underwriting.

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

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

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

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

25. Territorial Limits
The Insurer's liability to make any payment towards illness or accidental injury shall be to make payment within India and in Indian Rupees only for medical services or procedures rendered in or undertaken within India. The coverage under Global Hospitalization cover and Personal Accident shall be applicable worldwide.

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

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27. CONDITIONS WHEN A CLAIM ARISES

A. HOSPITALISATION CLAIM:

a. 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

Type of hospitalization	Turn Around Time	
Cashless - Admission in Network Hospital	**Planned Hospitalization:** pre-authorization has to be obtained 72 hours prior to the date of planned admission	**Emergency Hospitalization**: within 48 hours of an emergency admission
Reimbursement - Admission in Non - Network Hospital	claim intimation has to be given to us in writing or mail (E mail: customercare@cholams.murugappa,com) or phone (@ Toll free no. 1800-208-9100)within seven days from the date of hospitalization/injury/death.	

b. Procedure for Cashless claims: Obtain our pre-authorization 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-authorization has to be obtained 72 hours prior to the date of admission and within 48 hours of an emergency admission. Pre-authorization request shall, if we are satisfied as to the validity of the claim, specify:

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

c. Procedure for submission of Reimbursement Claims

1. Upon Hospitalization, the insured Person or his/her dependents shall provide us with fully particularized 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 recognized by

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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-authorized or not.

B. Claims Procedure applicable to PERSONAL ACCIDENT SECTION:

i. Claim Notification:

a. It shall be a condition precedent for any claim to be made by the **Insured** under this policy or for liability attaching to us hereunder that claim intimation is provided to the Insurer within 30 days by telephone through toll free number (**1800-208-9100**) or in writing by email (customercare@cholams.murugappa.com) / letter). The intimation should contain the following information:
   - Insured details (Name /Age/Gender)
   - Contact no & E-Mail ID.
   - Certificate Number.
   - Date of Accident.
   - Injury Details.

b. The insured / claimant shall provide the Insurer with details of the claim to be paid as listed below under claim documentation of the policy within 30 days from the date of occurrence of the Accident. Failure to furnish such details within such time as required shall not invalidate or reduce the claim, if the Insured person is able to satisfy the Company that it is was not reasonably possible to do so within such time.

c. The Insurer 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 of the Insured Person's claim, and may for these purposes require the Insured Person to be examined by a medical advisor nominated by the Insurer as often as and to the extent that either considers to be reasonably necessary.

d. The Insured/Policy Holder acknowledges and agrees that the payment of any claim by or on behalf of the Insurer shall not constitute on the part of the Insurer any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the Insured Person, it being agreed and recognised by the Insured that the Insurer is not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution.

e. The insured shall obtain and furnish to the Company copy of all bills, receipts and 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'.

ii. Claim documentation:

Following documents are to be submitted for processing of the claim along with the duly filled & signed claim form by the insured / nominee in addition to the documents listed in the table:

- KYC of the nominee / legal heir in case of death claim and KYC of the Insured for other claim under the policy.
- Account details with proof for NEFT of the nominee / legal heir in case of death claim and of the insured for other claims under the policy i.e. cancelled cheque, passbook copy has to be submitted with the below listed claim documents.
- Proof of identity and residence of the beneficiary for claims exceeding Rs 1 Lakh

Covers	Documents
Hospitalization Expenses / Infertility Treatment / Bariatric Surgery / Global Hospitalization cover / Home Care Expenses /	- 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.

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	- 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.
Compassionate Travel	- Documents as stated above and - Original ticket issued by common carrier for travelling from the place of residence to the place where the insured is hospitalised.
Repatriation of Mortal Remains	- Receipt for expenses incurred in connection with transportation of Mortal Remains
Personal Accident Cover	- Copy of FIR / Police Report, wherever necessary - Copy of Post Mortem Report/Coroner's report (If postmortem is conducted) - Copy or Panchanama / Inquest report - Death Certificate - Original Policy Certificate for deletion of name of the Insured person from the list.
Global Hospitalization Cover	- Documents as stated above and - Proof of diagnosis in India - Insured's Passport and Visa
Specs/ Contact lens/hearing aids	- Original payment receipt (Receipt should have Serial No) with Dr. Prescriptions
High End Diagnostics	- Original payment receipt (Receipt should have Serial No) - Original investigation reports with relevant Dr. prescription

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

Chola MS customer support operates 24 /7 basis and the contact details are as followed for any queries / grievances:
Toll Free Phone No : **1800-208-9100**
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: 1800-208-9100
E-Mail: help@cholams.murugappa.com

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

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29. 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.

30. 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.

31. Sum Insured Enhancement:
Sum Insured can be enhanced only at the time of renewal subject to reported claim status and health condition of the insured. If you decide to increase the sum insured at the time of renewal, the Sum Insured revision is subject to written application and our acceptance. 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 Waiting periods under Section 5.i, ii and iii above.

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

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

34. Automatic Termination
This **policy** shall terminate immediately on the earlier of the following events irrespective of the expiry date mentioned in the **policy schedule**
• Upon the demise of the covered person, in which case the **Company** will refund premium calculated on pro-rata basis for the unexpired period subject there being no claim under the policy.
• Upon exhaustion of the Sum Insured. However this will not affect the renewal for the subsequent period.

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

SECTION 8 – GRIEVANCE REDRESSAL
Mechanism for Grievance Redressal:-
In case of any grievance the insured person may contact the company through

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 9100, 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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Website : www.cholainsurance.com
Toll free : 1800 208 9100
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

In case of any dissatisfaction, you may represent the same to our Customer Service Team E-mail - Customercare@cholams.murugappa.com

In case you are still unhappy with the response or have not received a response within 10 days, you may escalate the same to our Nodal Desk E-mail - Nodalescalation@cholams.murugappa.com

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

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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,	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

Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur,	
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

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

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

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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 II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER

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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

Section 9: Medical Second Opinion-Add-on Cover

(on payment of additional premium)

1. GENERAL CONDITIONS

1. It is agreed and understood that this Add On Cover can only be bought along with the Underlying Plan and cannot be bought in isolation or as a separate product.
2. The Add On Cover is subject to the terms and conditions stated below and the Policy terms, conditions and applicable endorsements of the Underlying Plan.
3. The Add On Cover shall be available under your policy only if the same is specifically opted on payment of applicable premium and specified in the Policy Schedule.

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4. All applicable Terms and Conditions of the Underlying Policy shall apply to the Add on Cover.

2. COVERAGE

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.

2. a. Specific Conditions:
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

2. b. Specific Exclusions

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.

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E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

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3. DEFINITIONS

The terms defined below and at other junctures in the Add-on cover Wording have the meanings ascribed to them wherever they appear in the Add-on cover Wording 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. **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.

4. GENERAL CONDITIONS

4.1 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.

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

4.3. 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.

4.4 Disclaimer
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.

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.