Chola MS
GENERAL INSURANCE

THE SIMPLE WAY TO COVER YOUR
FAMILY'S HEALTHCARE NEEDS.

INTRODUCING

AROGYA SANJEEVANI POLICY, CHOLA MS

Arogya Sanjeevani Policy, Chola MS is a standard health indemnity insurance policy that provides financial protection against the unforeseen medical contingencies for you and your family. It provides you the flexibility of paying in multiple frequencies like monthly, quarterly, half-yearly or annually. You also get to enjoy discounts on premiums while we have your whole family covered.

BENEFITS

FAMILY COVER
Covers entire family including parents-in-law

FAMILY DISCOUNT
Discount of 5% for 3-5 members, 7% for 6-7 members, 10% for > 7 members

NO HEALTH CHECK-UP
No pre-policy health check-up before 50 years of age

TAX EXEMPTION
Up to ₹25,000
Up to ₹55,000 for senior citizens under section 80D of IT Act

ENTRY AGE
Adults: 18 - 65 years
Dependent Children: 90 days - 25 years

WHAT IS COVERED?

In Patient Hospitalisation Expenses:
Expenses covered for minimum 24 hours of hospitalisation

Emergency Ambulance Expenses:
Maximum of ₹2000 per hospitalisation

Day Care Procedures:
All day care procedures covered

Pre and Post Hospitalisation:
Covers the expenses for 30 days and 60 days respectively

AYUSH Coverage:
Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy

Dental Treatment and Plastic Surgery:
Necessitated due to disease or injury

COVERAGE OPTIONS

Sum Insured (in ₹)

50,000 | 1 Lakhs | 1.5 Lakhs | 2 Lakhs | 2.5 Lakhs | 3 Lakhs | 3.5 Lakhs | 4 Lakhs | 4.5 Lakhs | 5 Lakhs

5.5 Lakhs | 6 Lakhs | 6.5 Lakhs | 7 Lakhs | 7.5 Lakhs | 8 Lakhs | 8.5 Lakhs | 9 Lakhs | 9.5 Lakhs | 10 Lakhs

Individual

- Insured can avail cover for all family members as defined on individual sum insured basis.
- Self, spouse, parents, parents-in-law between 18 years to 65 years.
- Dependent children up to 4 shall be covered from the age of 3 months to 25 years.

Family floater

- Self, spouse and up to 4 dependent children, up to a maximum of 6 members can be covered. Coverage of proposer is not mandatory.
- Dependent children between the ages 3 months and 25 years can be insured provided either parent is getting insured under this policy.

Policy Period

- Policy shall be offered for a term of one year.

SCOPE OF COVER

The covers listed below are in-built policy benefits and shall be available to all insured persons in accordance with the procedures set out in the policy.

Benefits	
Hospitalisation expenses	Covered
Other expenses	Dental treatment necessitated due to disease or injury
	Plastic surgery, necessitated due to disease or injury
	Day care treatments
	Road ambulance - max. upto ₹2,000/- per hospitalisation
AYUSH	Covered without sublimits
Pre-hospitalisation	Up to 30 days
Post- hospitalisation	Up to 60 days

Sublimit / Co-Payment	
Room limits	2% of SI subject to a maximum of ₹5,000/- per day
ICU/ICCU	5% of SI subject to a maximum of ₹10,000/- per day
Co-payment	5% on every admissible claim
Cataract surgery	Up to 25% of SI or ₹40,000/- whichever is lower, per each eye in one policy year
Disease Specific limits - either as IP or as day care treatment	**Up to 50% of SI** 1. Uterine Artery Embolization and HIFU (high intensity focused ultrasound) 2. Balloon sinuplasty 3. Deep brain stimulation 4. Oral chemotherapy 5. Immunotherapy - monoclonal antibody to be given as injection 6. Intravitreal injections 7. Robotic surgeries 8. Stereotactic radio surgery 9. Bronchial thermoplasty 10. Vaporisation of the prostrate (green laser treatment or holmium laser treatment) 11. IONM (Intraoperative neuromonitoring) 12. Stem cell therapy: hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered
Renewal Benefits	
Cumulative Bonus	5% - 50%

Note:

1. Expenses of Hospitalisation for a minimum period of 24 consecutive hours shall only be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. In case of admission to a room /ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

WAITING PERIOD

The company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

1.1 Pre–Existing Diseases (Code – Excl 01)

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 of continuous coverage after the date of inception of the first policy with us.

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 norms on portability stipulated by IRDAI, 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 for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

1.2 First 30-Day Waiting Period (Code–Excl 03)

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.

1.3 Specific Waiting Period (Code–Excl 02)

a) Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first Policy with the Insurer. 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.

24-Month Waiting Period

i. Benign ENT disorders
ii. Tonsillectomy
iii. Adenoidectomy
iv. Mastoidectomy
v. Tympanoplasty
vi. Hysterectomy
vii. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps
viii. Benign prostate hypertrophy
ix. Cataract and age related eye ailments
x. Gastric/Duodenal Ulcer
xi. Gout and Rheumatism
xii. Hernia of all types
xiii. Hydrocele
xiv. Non-infective Arthritis
xv. Piles, Fissures and Fistula in anus
xvi. Pilonidal sinus, Sinusitis and related disorders
xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
xviii. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy
xix. Varicose Veins and Varicose ulcers
xx. Internal Congenital Anomalies

36-Month Waiting Period

i. Treatment for joint replacement unless arising from accident.
ii. Age-related Osteoarthritis and Osteoporosis.

EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

1. **Investigation & Evaluation (Code–Excl 04):**
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes.
   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–Excl 05):**
   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–Excl 06): 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.
    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 Type 2 diabetes

4. **Change-of-Gender Treatments (Code–Excl 07):** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. **Cosmetic or Plastic Surgery (Code–Excl 08):** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. **Hazardous or Adventure Sports (Code–Excl 09):** Expenses related to any treatment, necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. **Breach of Law (Code–Excl 10):** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers (Code–Excl 11):** Expenses incurred towards treatment in any hospital or by any medical practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to 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 **(Code–Excl 12)**.

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–Excl 13)**.

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–Excl 14)**.

12. **Refractive Error (Code–Excl 15):** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

13. **Unproven Treatments (Code–Excl 16):** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. **Sterility and Infertility (Code–Excl 17):** Expenses related to, sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational surrogacy
    d. Reversal of sterilization

15. **Maternity Expenses (Code–Excl 18):**
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy.
    b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

16. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolution, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and derailments of all kinds.

17. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For purpose of this exclusion:
    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
    b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

18. Any expenses incurred on domiciliary hospitalisation and OPD treatment.

19. Treatment taken outside the geographical limits of India.

20. In respect of existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to the coverage for specified ICD codes.

RENEWAL OF POLICY

The health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium clause of the policy.

1. Renewal shall not be denied on the ground that the Insured had made a claim or claims in the preceding years.
2. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy period.
3. At end of the Policy Period, the policy shall terminate and can be renewed with the Grace period to maintain the continuity benefits without Break in Policy. Coverage is not available during the grace period.

   If not renewed within Grace Period after due renewal date, the Policy shall terminate.

PREMIUM PAYMENT IN INSTALLMENTS

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

1. Grace Period of 15 days in case of Monthly and 30 days in case of Single/Half-yearly/Quarterly premium payment mode would be given to pay the instalment premium due for the policy.
2. The policy will be in force during such grace period and any claim arising during the grace period will be payable subject to policy terms and conditions.
3. The Benefits provided under – “Waiting Periods”, ”Specific Waiting Periods” Sections shall continue in the event of premium within the stipulated grace Period.
4. No interest will be charged if the instalment premium is not paid on due date.
5. In case the instalment premium due not received within the Grace Period , the Policy will get cancelled.
6. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

FREE LOOK PERIOD

Every policyholder of new individual health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy and to return the same if not acceptable.

Free Look Period shall not be applicable on renewals or at the time of porting/migrating the policy.

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

1. A refund of premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges, where the risk has not commenced.

or

2. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover, expenses if any incurred by the Company on medical examination of the policyholder and stamp duty charges.

or

3. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period, expenses if any incurred by the Company on medical examination of the policyholder and stamp duty charges.

CLAIMS PROCEDURE

1. Procedure for Cashless Claims

a. Treatment may be taken in a network provider as well as identified list of hospitals by GIC for common empanelment through anywhere cashless facility and is subject to pre authorisation by the Company or its authorised TPA.

b. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorisation.

c. The Company/TPA upon getting cashless request form and related medical information from the insured person/network provider will issue pre-authorisation letter to the hospital after verification.

d. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

e. The Company/TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medial details.

f. In case of denial of cashless access the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.

2. Procedure for Reimbursement of Claims

For reimbursement of claims the insured person may submit the necessary document to TPA (if applicable)/Company within the prescribed time limit as specified hereunder:

Sl. No	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalisation, day care ad pre-hospitalisation expenses	Within thirty days of discharge from hospital
2.	Reimbursement of post-hospitalisation expenses	Within fifteen days from completion of post-hospitalisation treatment

3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

a. Within 24 hours from the date of emergency hospitalisation required or before the insured person's discharge from Hospital, whichever is earlier.

b. At least 48 hours prior to admission in Hospital in case of a planned hospitalisation.

4. Documents to be Submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit:

a. Duly completed claim form
b. Photo identity proof of the patient
c. Medical practitioner's prescription advising admission
d. Original bills with itemized break-up
e. Payment receipts
f. Discharge summary including complete medical history of the patient along with other details
g. Investigation/diagnostic test reports etc., supported by the prescription from attending medical practitioner
h. OT notes or surgeon's certificate giving details of the operation performed (for surgical cases)
i. Sticker/invoice of the implants, wherever applicable
j. MLR (Medico Legal Report) copy if carried out and FIR (First Information report) if registered, where ever applicable
k. NEFT details (to enable direct credit of claim amount in bank account) and cancelled cheque
l. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML guidelines
m. Legal heir/succession certificate, wherever applicable
n. Any other relevant document required by Company/TPA for assessment of the claim

Note:

1. The company shall only accept bills/invoices/medical treatment related documents in the insured person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the company shall accept copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the company.
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the insured person.

CO-PAYMENT

Each and every claim under the policy shall be subject to a co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

TERRITORIAL LIMIT

All medical treatment for the purpose of this insurance will have to be taken in India only.

CANCELLATION

1. The policyholder may cancel this policy at any time during the term, by giving 7 days written notice in writing and in such an event, the Company shall

   a. refund proportionate premium for the unexpired policy period, if the term of policy upto one year and there is no claim(s) made during the policy period.

   b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

2. 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.

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. If such person is presently covered and has been continuously covered without any lapses under any Health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

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. 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 to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

PREMIUM PAYMENT

1. In case of floater option, the premium chargeable is based on the highest of the ages of all the insured persons and the scheme applicable based on number of persons covered. Taxes as applicable is to be charged on the premium.
2. The premium paid for covering self, spouse, dependent children and dependent parents is eligible for deduction under Section 80D of Income Tax Act.
3. AML norms as per IRDA guidelines currently in force shall be insisted upon.

MORATORIUM PERIOD

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

RISK 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%.

DISCOUNTS

FAMILY SIZE DISCOUNT FOR INDIVIDUAL POLICIES	
Size of the Family	**Discount (%)**
1 to 2 members	0
3 to 5 members	5%
6 to 7 members	7%
> 7 members	10%

LOADING

LOADING FOR MODE OF PAYMENT	
Instalment Frequency	**Loading (%)**
Monthly	4%
Quarterly	3%
Semi-Annually	2%

Please refer to our website for premium table.

REDRESSAL OF GRIEVANCE

Grievance - in case of any grievance relating to servicing the policy, the insured person may submit in writing to the policy issuing office or regional office for redressal.

For details of grievance officer, kindly refer the link **www.cholainsurance.com**
IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Insurance Ombudsman - the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of policy document.

No loading shall apply on renewals based on individual claims experience.

REACH US THROUGH WHATSAPP 7305234433

Chola MS
GENERAL INSURANCE

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