



Micro Insurance - Group Mediclaim Insurance Policy

1. INSURANCE:

1.1. WHEREAS THE POLICYHOLDER designated in the Schedule hereto has by a Proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein has applied to HDFC Ergo General Insurance Company Limited (hereinafter called the Company) for the insurance hereinafter set forth in respect of the INSURED PERSONS and has paid premium as consideration for such Insurance.

1.2. NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein, or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule, or during the continuance of this policy by renewal, any INSURED PERSON shall contract any DISEASE or sustain any INJURY and if such DISEASE or INJURY shall require any such INSURED PERSON, upon the advice of a duly qualified MEDICAL PRACTITIONER to incur hospitalisation or DOMICILIARY HOSPITALISATION EXPENSES for medical/surgical treatment at any HOSPITAL in India as an inpatient, the Company will pay the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such INSURED PERSON but not exceeding the sum insured for the person in any one period of insurance as mentioned in the scheduled hereto.

- a. Room, Boarding Expenses as provided by the HOSPITAL;
- b. Nursing Expenses;
- c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees;
- d. Anaesthesia, Blood, Oxygen, Operation theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, artificial Limbs and similar expenses.

NOTE: The above benefits are available for only for Allopathic Mode of Treatments. The Limit for ALTERNATIVE TREATMENT mode as licensed in India such as Homoeopathy, Ayurvedic, Unani and similar other recognised treatments requiring hospitalisation shall be restricted to 20% of the ANY ONE YEAR LIMIT subject to a maximum of Rs.25,000. The cover is available provided the treatment has been undertaken in a government **HOSPITAL** or in any institute recognized by government and / or accredited by Quality Council of India / National Accreditation Board on Health or any other government authorised institute.

1.3. Expenses on hospitalisation are admissible only if hospitalisation is for a minimum period of twenty-four (24) hours. However, this time limit will not apply to DAY CARE TREATMENT as per Annexure 2, taken in HOSPITAL where INSURED PERSON is discharged on the same day. Such treatment will be considered to be taken under Hospitalisation Benefit.



This condition will also not apply in case of stay in HOSPITAL of less than twenty-four (24) hours provided:

- a. the treatment is such that it necessitates hospitalisation and the procedure involves specialised infrastructural facilities available only in HOSPITALS; and
 - b. due to technological advances hospitalisation is required for less than twenty-four (24) hours.
- 1.4. ANY ONE ILLNESS will be deemed to mean continuous period of illness and it includes relapse within 45 days from date of discharge from the HOSPITAL / NURSING HOME where treatment was taken. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy provided the policy has been renewed with the Company.
- 1.5. It is further clarified that the Policy shall reimburse only those expenses which are for hospitalisation commencing from a date within the policy period. Even if the hospitalization spreads beyond the expiry date of the policy, the total benefit will not exceed the sum insured of the policy during which the INSURED PERSON was admitted to the HOSPITAL / NURSING HOME.
- 1.6. Pre-Hospitalisation: Relevant medical expenses incurred during period up to thirty (30) days prior to hospitalisation for DISEASE or INJURY sustained will be considered as part of claim mentioned under item 1.2 above.
- 1.7. Post Hospitalisation: Relevant medical expenses incurred during period up to sixty (60) days after Hospitalisation for DISEASE or INJURY sustained will be considered as part of claim as mentioned under item 1.2 above.
- 1.8. DOMICILIARY HOSPITALISATION EXPENSES is hereby covered subject to the following exclusions:
- a. Expenses incurred for pre and post HOSPITAL treatment; and
 - b. Expenses incurred for treatment for any of the following DISEASES:
 - 1.8.b.1. Asthma;
 - 1.8.b.2. Bronchitis;
 - 1.8.b.3. Chronic Nephritis and Nephrotic Syndrome;
 - 1.8.b.4. Diarrhoea and all type of Dysenteries including Gastro-enterities;
 - 1.8.b.5. Diabetes Mellitus Insipidus;
 - 1.8.b.6. Epilepsy;
 - 1.8.b.7. Hypertension;
 - 1.8.b.8. Influenza, Cough and cold;
 - 1.8.b.9. All Psychiatric or Psychosomatic Disorders;
 - 1.8.b.10. Pyrexia of unknown origin for less than 10 days;
 - 1.8.b.11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
 - 1.8.b.12. Arthritis, Gout and Rheumatism

The Annual Limit for DOMICILIARY HOSPITALISATION EXPENSE under the policy shall be restricted to 15% of the ANY ONE YEAR LIMIT stated in the Annexure of the Schedule subject to the maximum of Rs.50,000/-.



NOTE: The DOMICILIARY HOSPITALISATION EXPENSE cover shall be available to treatments taken only under the Allopathic Mode of Treatment subject to the above conditions.

1.9. MATERNITY EXPENSES Benefit is an optional benefit available on payment of additional premium. When MATERNITY EXPENSES Benefit is added in the policy schedule, exclusion 3.14 of the policy stands deleted. Pre and post natal expenses relating to MATERNITY EXPENSE is covered only if the same is specifically mentioned on the policy schedule.

2. DEFINITIONS:

2.1. ACCIDENT or ACCIDENTAL means a sudden, unforeseen and involuntary event caused by external and visible means.

2.2. ANY ONE YEAR LIMIT means SUM INSURED which shall be the amount stated in the Policy Schedule as such or limited to the specific insurance details in any Section of this Policy. The ANY ONE YEAR LIMIT shall be subject at all times to the terms and conditions of the Policy, including but not limited to the exclusions and any additional limitations and / or PER OCCURRENCE LIMIT noted in this Policy and Schedule.

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

2.4. CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

2.5. CONGENITAL ANOMALY refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- a. INTERNAL CONGENITAL ANOMALY which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly
- b. EXTERNAL CONGENITAL ANOMALY which is in the visible and accessible parts of the body is called External Congenital Anomaly.

2.6. CONTRIBUTION is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

2.7. CO-PAYMENT is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible costs. A co-payment does not reduce the sum insured.

2.8. DEDUCTIBLE is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the SUM INSURED.

2.9. DAY CARE CENTRE means any institution established for day care treatment of sickness and / or injuries or a medical set -u p within a hospital



and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- 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.

- 2.10. **DAY CARE TREATMENT** refers to medical treatment, and/or surgical procedure which is:
- a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
 - b. which would have otherwise required a hospitalization of more than 24 hours.

The company covers only specified Day-care Treatments, please refer to list as mentioned in Annexure 2. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

- 2.11. **DENTAL TREATMENT** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.
- 2.12. **DEPENDENT CHILD** refers to a child (natural or legally adopted or child from a previous marriage) of an **INSURED PERSON** or the **SPOUSE** of an **INSURED PERSON**, who is between the ages of three (3) months and up to and including the age of eighteen (18) years, or up to and including the age of twenty-five (25) years if in full time education at an accredited tertiary institution and does not have his / her independent sources of income.

- 2.13. **DOMICILIARY HOSPITALISATION** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
- a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
 - b. the patient takes treatment at home on account of non availability of room in a hospital.

- 2.14. **DISEASE** means a pathological condition of a part, organ, or system resulting from various causes, such as infection, pathological process, or environmental stress, and characterized by an identifiable group of signs or symptoms.

- 2.15. **ENDORSEMENT** means written evidence of an agreed change in the policy including but not limited to increase or decrease in the period, extent and nature of the cover.

- 2.16. **HOSPITAL / NURSING HOME** means any institution established for in- patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:



- a. has at least 10 inpatient beds, in those towns having a population of less than 1,000,000 and 15 inpatient beds in all other places;
 - b. has qualified nursing staff under its employment round the clock;
 - c. has qualified medical practitioner (s) in charge round the clock;
 - d. has a fully equipped operation theatre of its own where surgical procedures are carried out
 - e. maintains daily records of patients and will make these accessible to the company's authorized personnel.
- 2.17. **HOSPITALISATION** means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours
- 2.18. **ILLNESS** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
- a. **ACUTE CONDITION** - Acute condition is a medical condition that can be cured by Treatment
 - b. **CHRONIC CONDITION** - A 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 your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.
- 2.19. **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 resulting solely and independently of any other cause or any physical defect or infirmity existing before the Period of Insurance.
- 2.20. **INTENSIVE CARE UNIT** means an identified section, ward or wing of a HOSPITAL which is under the constant supervision of a dedicated MEDICAL PRACTITIONER(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards
- 2.21. **INPATIENT CARE** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
- 2.22. **INSURED PERSON** means anyone over the age of three (3) months and aged sixty five(65) years old or younger, except when the COMPANY, at its sole discretion, accepts anyone over sixty five(65) years old, for whom premium has been paid and who is identified in the Schedule as an INSURED PERSON. INSURED PERSON will include any one or more of the following:
- a. SPOUSE who permanently resides with the INSURED PERSON
 - b. DEPENDENT CHILDREN of an INSURED PERSON who
 - c. Are financially dependent on the INSURED PERSON



- d. Permanently reside with the INSURED PERSON
 - e. DEPENDENT PARENTS of the INSURED PERSON
- 2.23. MATERNITY EXPENSES BENEFIT means treatment taken in HOSPITAL arising from or traceable to pregnancy, childbirth including normal Caesarean section. This is an optional benefit available on payment of additional premium. When MATERNITY EXPENSES BENEFIT is opted for in the policy, exclusion 3.14 of the policy stands deleted. Maternity expense / treatment shall include the following Medical treatment Expenses:
- a. Medical Expenses for a delivery (including complicated deliveries and caesarean sections) incurred during Hospitalization;
 - b. The lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person;
 - c. Optionally Pre-natal and post-natal Medical Expenses for delivery or termination.
- 2.24. MEDICAL ADVISE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
- 2.25. 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.
- 2.26. MEDICAL PRACTITIONER is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.
The term MEDICAL PRACTITIONER includes qualified physicians, specialists and surgeons other than:
- a. an INSURED PERSON under this policy;
 - b. an INSURED PERSON'S employer or business partner;
 - c. an employee of the POLICYHOLDER; or
 - d. an IMMEDIATE FAMILY MEMBER of the INSURED PERSON. For purposes of this definition only, the term IMMEDIATE FAMILY MEMBER shall not be limited to natural persons resident in the same country as the INSURED PERSON. IMMEDIATE FAMILY MEMBER means an INSURED PERSON'S Spouse; children; children-in-law; siblings; siblings-in-law; parents; parents-in-law; grandparents; grandchildren; legal guardian, ward; step or adopted children; step-parents; aunts, uncles; nieces, and nephews, who reside in the same country as the INSURED PERSON.
- 2.27. MEDICALLY NECESSARY TREATMENT is defined as 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 the insured; must not exceed the level of care necessary to provide



- safe, adequate and appropriate medical care in scope, duration, or intensity;
- b. must have been prescribed by a medical practitioner,
 - c. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 2.28. NETWORK PROVIDER means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.
- 2.29. NON- NETWORK means any hospital, day care centre or other provider that is not part of the network.
- 2.30. NEWBORN BABY means those babies born to you and your spouse during the Policy Period Aged between 1 day and 90 days.
- 2.31. PER OCCURRENCE LIMIT means maximum amount that can be reimbursed for ANY ONE ILLNESS covered under the scope of the policy.
- 2.32. PERIOD OF INSURANCE means the Operative Time stated in the Schedule, commencing on or after the Policy Effective Date and terminating on or before the Policy Expiration Date.
- 2.33. POLICYHOLDER means the entity or person named as such in the Schedule.
- 2.34. POST-HOSPITALIZATION MEDICAL EXPENSES means Medical Expenses incurred immediately after the Insured Person is Hospitalised, provided that:
- a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 2.35. PRE-HOSPITALIZATION MEDICAL EXPENSES means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:
- a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 2.36. PRE-EXISTING CONDITION means any DISEASE or INJURY for which medical advice, diagnosis, care or treatment:
- a. was received by;
 - b. was recommended to; or
 - c. would have been sought by a reasonably prudent person, within 48 months prior to the first policy issued by an insurer. .
- Complications arising from a PRE-EXISTING CONDITION will be considered part of that PRE-EXISTING CONDITION. PRE-EXISTING CONDITION may be included for an additional charge.



- 2.37. **QUALIFIED NURSE** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- 2.38. **REASONABLE 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 .
- 2.39. **SPOUSE** means an **INSURED PERSON'S** husband or wife who is recognised as such by the laws of the jurisdiction in which they reside and who does not exceed sixty-five (65) years of age.
- 2.40. **SUM INSURED** means the amount stated in the policy Schedule as such or limited to the specific insurance details in any Section of this policy. The **SUM INSURED** shall be subject at all times to the terms and conditions of the policy, including but not limited to the exclusions and any additional limitations noted in the wording of each Section.
- 2.41. **SURGERY OR SURGICAL PROCEDURE / OPERATION** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a **MEDICAL PRACTITIONER**. manual and / or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life performed in a hospital or day care centre by a medical practitioner.
- 2.42. **OPD TREATMENT** is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
- 2.43. **TPA** means a Third Party Administrator as mentioned in the Schedule who is licensed by the Insurance Regulatory & Development Authority (IRDA) and is engaged for a fee or remuneration by whatever name called as may be specified in the agreement with the Company for providing Health Services to the **INSURED PERSON**.
- 2.44. **NOTIFICATION OF CLAIM** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.
- 2.45. The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
- 2.46. **"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.

- 2.47. SUBROGATION shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.
- 2.48. RENEWAL defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.
- 2.49. ROOM RENT shall mean the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses. Deductible is a cost sharing requirement that provides that we will not be liable for the amount of covered Medical Expenses, as specifically mentioned in the Policy Schedule, which has to be borne by You for each and every Claim during the Policy Period, before it becomes payable by Us under the Policy. This is to clarify that a deductible does not reduce the sum insured.
- 2.50. PORTABILITY means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.
- 2.51. UNPROVEN/EXPERIMENTAL TREATMENT is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven.

3. EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any INSURED PERSON in connection with or in respect to:

- 3.1. All DISEASEs or INJURIES which are a PRE-EXISTING CONDITION when the cover incepts for the first time..For the purpose of applying this condition, the date of inception of the initial mediclaim policy taken from any of the Indian Insurance Companies shall be taken provided the renewals have been continuous and without any break
- 3.2. Any DISEASE other than those stated in clause 3.3, contracted by the INSURED PERSON during the first thirty (30) days from the commencement date of the policy. This condition 3.2 shall not however, apply in case of the INSURED PERSON having been covered under this policy or Group Insurance Scheme with any one of the Indian Insurance Companies for a continuous preceding twelve (12) months without any break.

Note : These exclusions 3.1 and 3.2 shall not however apply if:

- a. in the opinion of a panel of MEDICAL PRACTITIONERS constituted by the Company for the purpose, the INSURED PERSON could not have known of the existence of the DISEASE or any symptoms or complaints



- thereof at the time of making the proposal for insurance to the Company;
and
- b. the INSURED PERSON had not taken any consultation, treatment or medication, in respect of the hospitalisation for which claim has been lodged under the policy, prior to taking the insurance.
- 3.3. During the first year of the operation of the insurance cover, the expenses for treatment of DISEASEs such as cataract, benign prostatic hyperthrophy, hysterectomy for menorrhagia or fibromyoma, hernia, hydrocele, congenital internal DISEASE / defects, fistula in anus, piles, Sinusitis and related disorders are not payable. If these DISEASEs (other than congenital internal DISEASE / defects) are a PRE-EXISTING CONDITION at the time of proposal, they will not be covered even during subsequent period of renewal. If the INSURED PERSON is aware for the existence of congenital internal DISEASE / defects before inception of policy, the same will be treated as a PRE-EXISTING CONDITION.
- 3.4. Claims arising from, as a consequence of or involving investigations, operations or treatment of a purely cosmetic nature; or for obesity; or undertaken to facilitate pregnancy or to cure impotence or to improve potency.
- 3.5. INJURY or DISEASE directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (whether war be declared or not).
- 3.6. Circumcision unless necessary for treatment of a DISEASE not excluded hereunder or as may be necessitated due to an ACCIDENT, vaccination or inoculation or change of life; or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an ACCIDENT or as a part of any illness.
- 3.7. The cost of spectacles and contact lenses, hearing aids, dental treatment or surgery of any kind unless requiring hospitalisation.
- 3.8. Convalescence, general debility, run-down condition or rest cure; congenital external DISEASE or congenital internal defects or anomalies for example Congenital heart anomalies like ASD, VSD, Tetralogy of Fallot etc.; sterility, venereal DISEASE, intentional self INJURY and use of intoxicating drugs/alcohol.
- 3.9. All expenses arising out of any condition directly or indirectly caused to or associated with Human T-cell Lymphographic Virus Type 111 (HTLB-111) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.
- 3.10. Charges incurred at HOSPITAL primarily for diagnostic, x-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any DISEASE or INJURY, for which confinement is required at a Hospital or at Home under Domiciliary Hospitalisation as defined.



- 3.11. Expenses on vitamins and tonics unless forming part of treatment for INJURY or DISEASEs as certified by the attending MEDICAL PRACTITIONER.
- 3.12. INJURY or DISEASE directly or indirectly caused by or contributed to by nuclear weapons/materials.
- 3.13. Loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.
- 3.14. Treatment arising from or traceable to pregnancy and childbirth (including voluntary termination of pregnancy) and childbirth, (including caesarean section) unless included as an add-on cover for which additional premium shall have to be paid.
- 3.15. Baby's expenditure is not covered under any circumstances unless it is a baby of 3 months or above as mentioned in clause 2.8 except where the policy is extended specifically as an add-on cover for which additional premium shall have to be paid.
- 3.16. Voluntary termination of pregnancy
- 3.17. Naturopathy treatment

4. CONDITIONS & CLAIMS PROCEDURE:

4.1. Part I – Conditions:

- a. Every notice or communication to be given or made under this policy other than claim shall be delivered in writing at the address of the policy issuing office as shown in the Schedule. The claim shall be referred to the TPA appointed for providing health care services.
- b. The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorised official of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the INSURED PERSON, insofar as they relate to anything to be done or complied with by the INSURED PERSON, shall be a condition predating to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.
- c. Upon the happening of any event which may give rise to a claim under this policy notice with full particulars shall be sent to the TPA within seven (7) days from the date of Hospitalisation.



- d. All supporting documents relating to the claim must be filed within thirty (30) days from the date of discharge from the hospital with the TPA. In case of post hospitalization treatment (limited to sixty (60) days), all claim documents should be submitted within seven (7) days after completion of such treatment to the TPA.
- e. The INSURED PERSON shall obtain and furnish to the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the TPA may require in dealing with claim.
- f. Any MEDICAL PRACTITIONER authorised by the Company shall be allowed to examine the INSURED PERSON in case of any alleged INJURY or DISEASE requiring hospitalisation when and so often as the same may reasonably be required on behalf of the Company.
- g. The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the INSURED PERSON or by any other person acting on his behalf.
- h. If, at the time when any claim arises under this policy, there is in existence two or more policies are taken by POLICYHOLDER / INSURED PERSON during a period from one or more insurer, the contribution clause shall not be applicable where the cover / benefit offered:
 - a. Is fixed in nature;
 - b. Does not have any relation to the treatment costs;

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, the company shall make the claim payments independent of payments received under other similar policies.

If two or more policies are taken by POLICYHOLDER/ INSURED PERSON during a period from one or more insurers to indemnify treatment costs, the company shall not apply the contribution clause, but the POLICYHOLDER shall have the right to require a settlement of his claim in terms of any of his policies.

- a. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the chosen policy.
- b. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers by whom the claim to be settled. In such cases, the company may settle the claim with contribution clause mentioned below.



c. Except in benefit policies, in case where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the policy.

The contribution clause shall imply that the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation, costs or expenses.

- i. Insured may cancel this Policy at any time by sending fifteen (15) days notice in writing to the Company or by returning the Policy and stating when thereafter cancellation is to take effect.

In the event of such cancellation the Company shall retain premium for the period that this Policy has been in force calculated in accordance with the short period rate table, less any duties and taxes Company cannot recover. However, there will be no refund of premium if you have made a claim, or you are entitled to make any claim under this Policy.

The Company reserves the right to cancel this Policy at any time by sending fifteen (15) days notice in writing to the Insured. In the event of such cancellation refund of premium shall be on pro-rata basis.

The Company also reserves the right to cancel this Policy from inception immediately upon becoming aware of any mis-representation, fraud, non-disclosure of material facts or non-cooperation by or on behalf of the Insured. No refund of premium shall be allowed in such cases.

Notice of cancellation will be mailed to the Insured at an address set forth in the Policy Schedule, and will indicate the date of termination. If notice of cancellation is mailed, proof of mailing will be sufficient proof of notice.

PERIOD ON RISK RATE OF PREMIUM TO BE CHARGED

Upto one month 1/4 of the annual rate
Upto three months 1/2 of the annual rate
Upto six months 3/4th of the annual rate
Exceeding six months Full annual rate

- j. If any difference shall arise between the POLICYHOLDER and the Company as to the quantum to be paid under this policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of two disinterested persons as arbitrators, who shall together proceed to appoint an umpire. The two arbitrators respectively shall be appointed in writing by the Company and the POLICYHOLDER within 30 days after having been required so to do in writing by the other party and the provisions of the Arbitration and Conciliation Act, 1996, as amended from time to time and for the time being in force, shall apply to such arbitration.



In case either the Company or the POLICYHOLDER refuses or fails to appoint an arbitrator within 30 days after receipt of notice in writing requiring an appointment, the other party shall be at liberty to appoint a sole arbitrator.

It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that the award by such arbitrator, arbitrators or umpire of the amount of the loss or damage shall be first obtained.

The venue of the arbitration proceedings shall be at the Corporate Office of the Company which is currently situated at 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai 400059.

It is clearly agreed and understood that no difference or dispute shall be referred to arbitration as herein before provided if the Company has disputed or rejected liability under or in respect of this policy.

- k. In no case whatsoever shall the Company be liable under the policy after the expiry of 12 months of the happening of INJURY or DISEASE resulting in a claim under the policy unless such claim is made the subject matter of pending legal action or arbitration. It is hereby expressly agreed and declared that if the Company disclaims liability to the INSURED PERSON for any claim hereunder mentioned, and such claim is not, within 12 calendar months from the date of such disclaimer, made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable.
- l. The Company shall be under no obligation to renew the policy on expiry of the period for which premium has been paid. The Company reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This policy may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The Company, however, shall not be bound to give notice that the policy is due for renewal or to accept any renewal premium. Unless renewed as herein provided, this policy shall automatically terminate at the expiry of the period for which premium has already been paid.
- m. All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.
- n. This Policy shall be governed by the laws of India and the courts in Mumbai alone shall have jurisdiction in any dispute arising hereunder.
- o. Upon settlement of the claim made under the policy, the Company shall be entitled to any amount paid by or recoverable from anyone on any ground whatsoever and shall be received or recovered by the Company. The person covered under the policy and all persons claiming on his / her behalf shall give to the Company all necessary information and assistance to enable the Company to secure and recover such amount



including subrogation. The Company shall, if necessary, be entitled to sue at its own expense in the name of such person covered under the policy or persons claiming on his / her behalf for recovery of amounts from such persons for which they may be liable. In the event of any such payment being received by the person covered under the policy directly or by other persons on their behalf, it shall be made over by him / her to the Company forthwith.

- p. Where proposal forms are not received, information obtained from the POLICY HOLDER or INSURED PERSON whether orally or otherwise is captured in the policy document. The POLICY HOLDER or INSURED PERSON shall point out to the Company, discrepancies, if any, in the information contained in the policy document or Certificate of Insurance, as applicable, within 15 days from policy / certificate issue date after which information contained in the policy or Certificate of Insurance shall be deemed to have been accepted as correct.
- q. Any person who has a grievance against the Company, may himself or through his legal heirs make a complaint in writing to the Insurance Ombudsman in accordance with the procedure contained in The Redressal of Public Grievance Rules, 1998 (Ombudsman Rules). Proviso to Rule 16(2) of the Ombudsman Rules however, limits compensation that may be awarded by the Ombudsman, to the lower of compensation necessary to cover the loss or damage suffered by the Insured as a direct consequence of the insured peril or Rs. 20 lakhs (Rupees Twenty Lakhs Only) inclusive of ex-gratia and other expenses. A copy of the said Rules shall be made available by the Company upon prior written request by the insured.

4.2. PART II –Claims Procedures:

- a. Treatment taken in a Network Hospital means treatment given by a provider of health care services, this means a provider that has a participation agreement in effect with us or with our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons. TPA (THIRD PARTY ADMINISTRATOR) is a service provider that has been selected by HDFC Ergo General Insurance Company to provide Third Party Administration services to its policyholders.
- b. Treatment taken in a Non-Network hospital means treatment given in any hospital out of the Network mentioned above. TPA Role:
 - 4.2.b.1. It is a condition precedent to the Company's Liability under this policy that in the event of any disease / illness/ accidental bodily injury that may give rise to a claim, the insured person or the insured person's representative contact and intimates to the TPA who has been appointed under the policy to provide claim services.
 - 4.2.b.2. All certificates, information and evidence required by the Company shall be furnished at no expense to the Company and shall be in such form and of such nature as the Company may prescribe. When required by the Company, at its own expense, the



Insured Person shall submit to medical examination in respect of any alleged claim that may give rise to a benefit being paid.

- 4.2.b.3. No sum payable under this Policy shall carry interest.
- 4.2.b.4. In the event of a claim under this Policy, the Policyholder, the Insured Person and the Beneficiary, if applicable, must fully co-operate with the Company in its handling of the claim including, but not limited to, the timely submission of all medical and other reports, and full co-operation with all physical examinations that the Company may require.
- 4.2.b.5. Medical advice of a Physician shall be sought and followed promptly on the occurrence of any Bodily Injury or Sickness and the Company shall not be liable for any part of any claim which in the opinion of a Physician appointed by the Company arises from the unreasonable or willful neglect or failure of an Insured Person to seek and remain under the care of a Physician.
- 4.2.b.6. Treatment taken in a Non-Network hospital means treatment given in any hospital out of the Network mentioned in the 'Membership Guide' which is provided for your reference at the time of enrolment under the policy.
- 4.2.b.7. Treatment taken in a Network Hospital means treatment given by a provider of health care services, this means a provider that has a participation agreement in effect with our TPA (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons. TPA as mentioned in the Schedule is a service provider selected by HDFC Ergo General Insurance Company to provide Third Party Administration services to its policyholders. Any changes in the network will be informed to the policyholders by TPA.
- 4.2.b.8. The claims eligibility protocol shall be as follows:
 - a. All hospitalization events need to be pre-authorized by TPA.
 - b. Reimbursement of claims for hospitalizations that have not been pre-authorized will be processed by the TPA at the discretion of the insurer
 - c. Pre-authorization needs to be done at least 48 hours prior to a planned hospitalization
 - d. For emergency hospitalizations, pre-authorization should be done within 24 hours of admission
 - e. The insured person may choose to seek hospitalization either at a network or non-network hospital
 - f. For network hospitalizations, the insured will be eligible for credit facilities subject to fulfilling the eligibility criteria as per the policy
 - g. In the event of complications during hospitalization or a change in course of treatment, the insured should notify TPA accordingly.
 - h. In the event of non-notification, the insured's claim for the unauthorized treatment is liable to be rejected by the insurer.
 - i. For credit hospitalizations, all expenses that are excluded from the benefits are payable by the insured at discharge.
 - j. For credit hospitalizations, the bills/supporting documents will be forwarded to TPA by the hospital/nursing home.



- k. Pre and post hospitalization bills will be forwarded by the insured to TPA
 - l. For non-credit hospitalizations, the bills will be settled by the insured and sent along with supporting documents to TPA
 - m. All original documents will be supported by a claim form
 - n. Reimbursement is subject to receiving all relevant documents and a completed claim form
 - o. For non-network hospitalizations, there would be a co-payment of 10 percent of admissible claim amount. The co-payment shall be deducted from the claims reimbursable and the balance shall be issued to the insured.
- 4.2.b.9. Pre-Authorization means Review of "need" for inpatient care or other care before admission. This refers to a decision made by the payer, TPA or insurance company prior to admission. The payer determines whether or not the payer will pay for the service.
- 4.2.b.10. FOR THE REMOVAL OF DOUBTS IT IS EXPRESSLY CLARIFIED THAT IN THE EVENT OF A CONFLICT BETWEEN ANY RULES, REGULATIONS, REQUIREMENTS, STIPULATIONS, AUTHORIZATIONS, CONDITIONS OR WARRANTIES ISSUED / MADE / REQUESTED BY THE TPA AND THE COMPANY, THOSE MADE BY THE COMPANY SHALL PREVAIL.
5. MATERNITY EXPENSES BENEFIT EXTENSION (Wherever applicable)
- 5.1. This is an optional cover which can be obtained for an additional premium for all the INSURED PERSONS under the policy.
- 5.2. Option for MATERNITY EXPENSES BENEFITS has to be exercised at the inception of the policy period and no refund is allowable in case of INSURED PERSON'S cancellation of this option during currency of the policy.
- 5.3. The maximum benefit allowable under this clause will be up to the sum insured shown in the Schedule..
- 5.4. Special conditions applicable to MATERNITY EXPENSES BENEFITS Extension:
- a. These Benefits are admissible only if the expenses are incurred in HOSPITAL as an inpatient in India.
 - b. A waiting period of nine (9) months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, mis-carriage or abortion induced by ACCIDENT or other medical emergency.
 - c. Claim in respect of delivery for only first two (2) children and/or operations associated therewith will be considered in respect of any one INSURED PERSON covered under the policy or any renewal thereof. Those INSURED PERSONS who are already having two (2) or more living children will not be eligible for this benefit.
 - d. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve (12) weeks from the date of conception are not covered.
 - e. Pre-natal and post-natal expenses are not covered unless admitted in HOSPITAL and treatment is taken there.
- 5.5. When this policy is extended to include Maternity Expenses benefit, the exclusion 3.14 of the policy stands deleted



GRIEVANCE REDRESSAL PROCEDURE

If you have a grievance that you wish us to redress, you may contact us with the details of your grievance through:

- Call Center (Toll free helpline)
1800 2 700 700 (accessible from any Mobile and Landline within India)
1800 226 226 (accessible from any MTNL and BSNL Lines)
- Emails – grievance@hdfcergo.com
- Designated Grievance Officer in each branch.
- Company Website – www.hdfcergo.com
- Fax : 022 - 66383699
- Courier : Any of our Branch office or corporate office

You may also approach the Complaint & Grievance (C&G) Cell at any of our branches with the details of your grievance during our working hours from Monday to Friday.

If you are not satisfied with our redressal of your grievance through one of the above methods, you may contact our Head of Customer Service at

The Complaint & Grievance Cell,
HDFC ERGO General Insurance Company Ltd.
6th Floor, Leela Business Park,
Andheri Kurla Road,
Andheri East, Mumbai – 400059

In case you are not satisfied with the response / resolution given / offered by the C&G cell, then you can write to the Principal Grievance Officer of the Company at the following address

To the Principal Grievance Officer
HDFC ERGO General Insurance Company Limited
6th floor, Leela Business Park.
Andheri Kurla Road,
Andheri (E), Mumbai – 400059
e-mail: principalgrievanceofficer@hdfcergo.com

You may also approach the nearest Insurance Ombudsman for resolution of your grievance. The contact details of Ombudsman offices are mentioned below if your grievance pertains to:

- Insurance claim that has been rejected or dispute of a claim on legal construction of the policy
- Delay in settlement of claim
- Dispute with regard to premium
- Non-receipt of your insurance document



LIST OF INSURANCE OMBUDSMEN

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, 5, Navyug Colony, Nr. C.U. Shah College, Ashram Road, AHMEDABAD-380 014. Tel.:- 079-27546150 / 139 Fax : 079-27546142 Email ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)-462011 Tel.:- 0755-2769200/201/202 Fax : 0755-2769203 Email bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455 / 2596461 Fax : 0674-2596429 Email ioobbsr@dataone.in	Orissa
CHANDIGARH	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D,	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh

HDFC ERGO General Insurance Company Limited



	CHANDIGARH-160 017. Tel.:- 0172-2706468 / 5861 Fax : 0172-2708274 Email ombchd@yahoo.co.in	
CHENNAI	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.:- 044-24333668 /664 / 678 Fax : 044-24333664 Email chennaiinsuranceombudsman@g mail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-23239611 /7539 /7532 Fax : 011-23230858 Email iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Insurance Ombudsman, Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.:- 0361-2131307 Fax : 0361-2732937 Email ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel : 040-23325325 /23312122 Fax: 040-23376599 Email insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry



KOCHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759 /2358734 /9338 Fax : 0484-2359336 Email iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, Kolkatta – 700 072. Tel: 033 22124346 /39 Fax: 033 22124341 Email:iombsbpa@bsnl.in	West Bengal , Bihar , Jharkhand and UT of Andaman & Nicobar Islands , Sikkim
LUCKNOW	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2201188 /31330 /1 Fax : 0522-2231310 Email insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel : 022-26106928 /360 /6552 /6960 Fax : 022-26106052 Email ombudsmanmumbai@gmail.com	Maharashtra , Goa

HDFC ERGO General Insurance Company Limited



Annexure 1 – Member Data
Annexure 2 – Day Care Treatments
Annexure 3 – Non Medical Expenses