HDFC ERGO General Insurance

my:jeevika Medisure Micro Insurance - CSC
Policy Wording

I. PREAMBLE

The Insured named in the Schedule has, by a Proposal, declaration and/or medical check-up which shall be the basis of the contract and shall be deemed to be incorporated herein, applied to HDFC ERGO General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth.

Subject to the terms, conditions, exclusions, stipulations and definitions contained herein or endorsed or otherwise expressed hereon, if during the **Policy Period**, the Insured/Insured Person shall contract any disease or illness or suffer any injury and is required to undergo treatment by way of i) Hospitalisation in any Hospital/Nursing Home in India (hereinafter called "Hospital") upon the advice of a duly qualified Medical Practitioner, the Company agrees to reimburse to the Insured/Insured Person or his/her nominee, medical expenses related to such treatment as per coverage under this Policy, not exceeding the **Sum Insured** for all claims during such **Policy Period.**

II. DEFINITIONS

Following words and expressions which are defined to bear the same meaning wherever they appear in this Policy:

"We/Our/Us" means HDFC ERGO General Insurance Company Limited.

"You/Your/Insured/Insured Person" means the person(s) named as Insured/Insured Person in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

"Accident" is a sudden, unforeseen and involuntary event caused by external and visible and violent means.

"Any one illness" means continuous Period of Illness and it includes relapse with in 45 days from the date of hospitalization at the Hospital/Nursing home where treatment may have been taken

"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.

"Cancellation" defines the terms on which the Policy contract can be terminated either by the Insurer or the Insured by giving sufficient notice to other which is not lower than period of 15 days.

Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

"External Congenital anomaly" means a condition(s) which is in visible and accessible parts of the body

"Internal Congenital anomaly" means a condition(s) which is not in visible and accessible part of the body.

"Co-payment" is a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specific percentage of the admissible Claim amount. A Co-payment is applicable on a claim and does not reduce the Sum Insured.

Condition Precedent: shall mean Policy term or condition upon which the Insurers liability under the Policy is conditional upon.

Commencement Date/Inception Date: means the commencement date of this Policy as specified in the Schedule.

Contribution: is essentially the right of the Company to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Day Care treatment: refers to medical treatment and/or surgical procedure which is

- undertaken under General or Local Anaesthesia in a hospital/day care centre for less than 24 hours due to technological advancement, and
- which would have otherwise required hospitalization of more than 24 hours.
- Treatment taken as an outpatient is not included under the Policy.

Day Care Centre: A Day care centre means any institution established for day care treatment of illness and/or injuries or a medical set up with in a hospital and which has been registered with 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 fully equipped operation theater of its own where surgical procedures are carried out
- Maintains daily record of patients and will make these accessible to the Insurance company's authorized personnel.

Dental treatment: is a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants

Dependents: mean only the family members listed below:

i. Insured's legally married spouse ,
ii. Insured's dependent children – being your children (natural or legally adopted) aged between 6 months and 18 years, who is/are financially dependent on the primary insured or proposer and does not have his / her independent sources of income.
iii. Insured's parents or parents in-law

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

Disclosure to information norm: The Policy shall be void and all Premium paid here on shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
Domiciliary hospitalization: means medical treatment actually taken at home for a period exceeding 3 days, for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually undertaken while confined at home under medical advice and under any of the following compelling 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 a room in a hospital.

Emergency Care: means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and required immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
"Family Floater" means a Policy described as such in the Schedule where under the Insured and his or her Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents the Company's maximum liability for any and all claims made by the Insured and/or all of the Dependents during the Policy Period.

Grace Period: means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

"Hospital/Nursing Home" means any institution established for in-patient care and day care treatment of Illness 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 the minimum criterias as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- 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 will make these accessible to the respective Insurance company's authorized personnel.

Hospitalization: means admission in a Hospital/Nursing Home for minimum period of 24 consecutive hours in Inpatient Care except for specified procedures/treatments, where such admission could be for period of less than 24 consecutive hours.

"Hospitalisation Expenses" means expenses for treatment in any Instance of Illness or accidental injury as In Patient in a Hospital/Nursing Home for a minimum period of 24 hours (except in respect of Day Care Treatment), as admissible under the Policy.

Intensive Care Unit: 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.

"Instance of Illness" means treatment for a continuous period and includes relapse within 45 days from the date of last consultation at the Hospital/Nursing Home where treatment was taken. Occurrence of same illness after a lapse of 45 days will be considered as fresh illness for the purpose of this Policy.

Illness: means sickness or disease or a pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy period and requires medical treatment.

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.

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.

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"Injury" means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

"In-patient" means the person(s) named in the Schedule to this Policy who is/are admitted to Hospital/Nursing Home and stays for at least 24 hours for the sole purpose of receiving medical treatment covered under the Policy.

"Inpatient Care" means a treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

"Insured/Insured Person" means the person(s) named in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

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

"Medical Charges" mean reasonable charges unavoidably incurred by the Insured/Insured Person for the medical treatment of disease, illness or injury, the subject matter of the claim as an In-patient in a Hospital/ Nursing Home, and includes the costs as defined under Hospitalisation and Pre & Post Hospitalisation Expenses.

"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 the scope and jurisdiction of license, provided that this person is not the Insured/Insured Person or a member of his/her family.

"Medical Expenses" means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account o f 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.

Medical Advise: Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"Medically Necessary" treatment means any treatment, tests, medication, or stay in a Hospital/Nursing Home which

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

"New Born Baby" means those babies born to the Insured/Insured Person and his/her lawfully wedded spouse during the Policy Period aged between 1 day and 90 days both days inclusive.

"Network provider" means hospitals or health care providers enlisted by an insurer or a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

"Non Network" means any hospital, day care centre or other provider that is not part of the list of Network.

Notification of a 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.

OPD Treatment (Outpatient): OPD treatment is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for a diagnosis and treatment based on the advice of a medical practitioner. The Insured is not admitted as a Day Care or Inpatient.

"Policy" means this Policy document, the Proposal Form, including endorsements and the Schedule.

"Policy Period" means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.

"Policy Year" means a year from the date of inception.

"Proposal Form" means the proposal and any other information given by the Insured to the company prior to the inception of the Policy which forms the basis of this contract of insurance.

"Post-hospitalisation expenses" means relevant medical expenses incurred during a period upto 60 days after hospitalisation for treatment of disease, illness or injury sustained and considered as part of a claim for Hospitalisation admissible under this Policy.

Pre-existing disease means any disease/illness/injury or related condition for which Insured Person(s) had signs or symptoms, and / or diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first Policy taken from Us.

Pre Hospitalization Medical Expenses: means medical expenses incurred immediately before the Insured Person is hospitalized provided that;

i. such Medical Expenses are incurred for the same condition for which the Insured Persons's hospitalization was required and
ii. The Inpatient Hospitalization claim for such hospitalization is admissible by Us

Post Hospitalization Medical Expenses: means medical expenses incurred immediately after the Insured Person is discharged provided that;

i. such medical expenses are incurred for the same condition for which the Insured Person's hospitalization was required and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by Us

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Portability: Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another or from one plan to another plan o f the same insurer, provided the previous policy has been maintained without any break.

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

"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 among comparable providers only, taking into account the nature of the illness / injury involved .

Renewal: 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 and Cumulative Bonus (if applicable).

Room Rent: means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Subrogation: 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.

"Sum Insured" means, subject to terms, conditions and exclusions of this Policy, the Sum Insured representing the Company's maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of the Insured/ Insured Person.

"Surgery" or "Surgical procedure" means 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/Nursing Home or Day Care centre by a Medical Practitioner.

"Third Party Administrator or TPA/Service Provider" means an organisation or institution that is licensed by the IRDA to act as a TPA by the Company to provide Policy and claims facilitation services to the Insured/Insured Person and the Company.

Alternative Treatment: Alternative treatments are forms of treatments other than treatment under "Allopathy" or "Modern Medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Unproven/Experimental treatment: Treatment including drug experimental therapy which is not based on established medical practice in India and is a treatment experimental or unproven.

III. SCOPE OF COVER

The Company hereby agrees to pay in respect of an admissible claim, any or all of the following **Benefits** subject to the **Sum Insured**, limits, terms, conditions and exclusions contained or otherwise expressed in this Policy.

1. **Hospitalisation Expenses**

   If any Insured Person suffers an Illness or Accident during the Policy Period requiring Hospitalization, then Company will pay:

   a) Room Rent/ Boarding & Nursing
   b) ICU Rent/Boarding & Nursing
   c) Fees of Surgeon, Anesthetist, Nurses and Specialists
   d) Cost of Operation Theatre, diagnostic tests, medicines, blood, oxygen and cost of prosthetic and other devices or equipment if implanted internally like pacemaker during a Surgical Procedure

   Provided always that Room Rent/Boarding & Nursing charges will be payable up to a maximum of Rs 300/- per day or actual whichever is lower and Any One Illness expenses will be payable up to a maximum of Rs 12,500/-.

2. **Pre-Hospitalisation Expenses**

   Company will pay the Medical Expenses incurred in the 30 days immediately before Insured is Hospitalized, provided that:

   i. Such Medical Expenses were in fact incurred for the same condition requiring subsequent Hospitalization, and;
   ii. We have accepted the claim under Section 1. “Hospitalization expenses.”

3. **Post-Hospitalisation Expenses**

   Company will pay the Medical Expenses incurred in the 60 days immediately after Insured is discharged, provided that:

   i. Such Medical Expenses were in fact incurred for the same condition for which Insured’s Hospitalization was required, and;
   ii. We have accepted the Claim under section 1a. ”Inpatient Hospitalization expenses”

4. Day Care expenses

Company will pay the Medical Expenses incurred for a Day Care Treatment where the treatment or surgery is taken by Insured as an inpatient and;

- Which is undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a hospitalization of more than 24 hours.

Provided always that Room Rent/Boarding & Nursing charges will be payable up to a maximum of Rs 300/- per day or actual whichever is lower and Any One Illness expenses will be payable up to a maximum of Rs 12,500/-.

5. Non-Allopathic Treatment

This Policy provides for reimbursement of expenses incurred towards treatment of disease/illness/injury up to Rs 7500/- per illness and 12,500/- per policy where the treatment taken in under Ayurvedic system of medicine. Minimum 24 hours of Hospitalisation is a must.

IV. EXCLUSIONS

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. All pre-existing diseases / illness / injury / conditions as defined in the Policy, until 48 months of continuous covers have elapsed since inception of the first Policy with us.
2. Any disease contracted and/or medical expenses incurred in respect of any disease/illness by the Insured/Insured Person during the first 30 days from the commencement date of the Policy except in case of accidental injuries.
3. All expenses along with their complications on treatment towards Cataract, Hysterectomy for Menorrhagia or Fibromyoma, Knee Replacement Surgery (other than caused by an accident), Joint Replacement Surgery (other than caused by accident), Prolapse of Intervertibral discs(other than caused by accident), Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary and biliary systems, Benign Prostate Hypertrophy, Hydrocele, Congenital internal disease/defect, Fistula in anus, Piles, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps, and any type of Breast lumps, Hypertension and Diabetes and related complications during the first two years(24 months) of continuous operation of this insurance cover.
   Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper/Hypoglycemic Shocks.
   Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nehpropathy, Internal Bleed/Haemorrhages. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing exclusion 1 above shall apply.
4. Any Domiciliary Hospitalization / Treatment.
5. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
6. Genetic disorder and stem cell implantation/surgery.
7. Dental treatment or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth

disease or damage.

8. Birth control procedures, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception.
9. Any treatment arising from or traceable to pregnancy, childbirth including caesarean section. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
10. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, vaccinations except post-bite treatment, issue of medical certificates and examinations as to suitability for employment or travel.
11. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III) or Lymphadinopathy Associated Virus (LAV) or Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV and sexually transmitted diseases.
12. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
13. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
14. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
15. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD)
16. Treatment for general debility, ageing, convalescence, run down condition or rest cure, congenital anomalies or defects, sterility, infertility including IVF, impotency, venereal disease, puberty, menopause or intentional self-injury, suicide or attempted suicide.
17. Certification / Diagnosis / Treatment by a family member or from persons not registered as Medical Practitioners under the respective Medical Councils, or any diagnosis or treatment that is- i) not scientifically recognized; ii) experimental; iii) unproven.
18. Ailment requiring treatment due to use or abuse of any substance, intoxicating drug or alcohol and treatment for de-addiction, or rehabilitation.
19. Any illness or hospitalisation arising or resulting from the Insured/Insured person or any of his family members committing any breach of law with criminal intent.
20. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
21. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised.
22. Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganization of personality or mind, or emotions or behaviour, Parkinsons or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition").
23. Any cosmetic surgery unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity or treatment/surgery /complications/illness arising as a consequence thereof.
24. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other

diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital/Nursing Home.

25. Costs of donor screening or organ.
26. Any form of Non-Allopathic treatment, Naturopathy, hydrotherapy, Homeopathy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine except Ayurvedic treatment up to the limits covered.
27. Change of treatment from one system of medicine to another unless recommended by the Medical Practitioner /Hospital under whom the treatment is taken,
28. Insured/ Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or participating or involvement in naval, military or air force operation.
29. Insured/Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air Charter Company.
30. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel/nuclear weapon/material or from any nuclear waste from the combustion of nuclear fuel, or chemical or biological weapons.
31. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities (whether war be declared or not or caused during service in the armed forces of any country), civil war, rebellion, revolution, insurrection, military or usurped power.
32. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured/Insured Person was hospitalized, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home.
33. Service charges or any other charges levied by the hospital, except registration/admission charges.

V. CLAIMS PROCEDURE

It is a condition precedent to the Company's liability that upon the discovery or happening of any disease/illness/injury that may give rise to a claim under this Policy, the Insured/Insured Person shall:-

1. Claim Notification

Give immediate notice to the TPA named in this Policy/Health Card, by calling the Help Line number as specified in the Policy/Health Card, or in writing to the address shown in the Schedule with particulars as below.

Policy Number,

Name of the Insured/Insured Person availing treatment,

Nature of disease/illness/injury,

Name and address of the attending Medical Practitioner/Hospital

Date of admission & probable date of discharge

Approximate Claim Expenses

Any other relevant information

Intimation of claim must be done at least 72 hours prior to hospitalisation in case of planned hospitalisation and within 24 hours of hospitalisation in case of an emergency hospitalisation.

2. Cashless Facility for Hospitalisation

i) The Company may provide Cashless facility for Hospitalisation expenses either directly or through the Third Party Administrator (TPA) if treatment is undergone at a **Network Hospital** by issue of pre-authorization by the Company or the TPA.

ii) For the purpose of considering pre-authorization and Cashless facility, the Insured/Insured Person shall submit to the TPA complete information of the disease, illness or injury requiring treatment along with necessary certification from the Medical Practitioner and/or Hospital.

iii) If claim for treatment appears admissible, Company or TPA shall issue pre-authorization to the Hospital concerned for Cashless facility whereby Hospitalisation expenses shall be paid directly by the Company directly or through the TPA as confirmed in the pre-authorization.

iv) Cashless facility for hospitalisation will not be available for treatment in Non-Network Hospital and may be declined even for treatment at Network Hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such a case, Insured/Insured Person shall bear the expenses and claim reimbursement, immediately after discharge from Hospital/Nursing Home in accordance with the stipulations herein.

3. Claim Processing for Reimbursement

i) The Insured/Insured Person shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 30 days of discharge from Hospital the following:-

- Claim Form Duly filled with requisite information and signed by Insured & Hospital
- Copy of the claim intimation
- Original Hospital Main Bill
- Original Hospital Bill break up (Where issued by the Hospital)
- Original Hospital Bill Payment Receipt
- Hospital Discharge Card/Summary
- Original Pharmacy Bill with supporting prescriptions
- Medical Investigation report: ECG/X-Ray/USG/CT/MRI/Histopathology/pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
- All Doctor's consultation note: confirming provisional & final diagnosis/advise for admission/medical complication/proposed line of treatment/past medical history
- Original bills and receipts for claiming Ambulance charges(if any)
- By signing the claim form you are authorizing us to collect the following documents from the Hospital. If you have obtained these documents, then please submit the same
- Operation Theatre Notes in surgical cases
- Bar code sticker & Invoice for implants and prosthesis (if used)

- In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident
- Indoor case papers

Pre and Post hospitalization Claims documents

- Duly filled claim form(s)(If claimed Separately)
- Pharmacy Bills with supporting prescriptions
- Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- All Doctor's consultation note with original bills and receipts for claiming Doctors fees,

ii) The Insured/Insured Person shall submit to the TPA at his/her own expense, documents pertaining to the post hospitalization claim within 15 days from the date of expiry of post hospitalsation coverage period.
iii) The Insured/Insured Person shall at any time as may be required authorize and permit the TPA and/or the Company or anyone deputed by them in this behalf to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.
iv) If required by the Company or the TPA, the Insured/Insured Person shall submit to medical examination by any Medical Practitioner designated by the Company or the TPA.
The Company may , at its sole discretion, call for additional information and/or carry out verification/investigation on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the assessment of loss. Verification carried out, if any, will be done by individuals or entities authorized by the Company to carry out such verification/investigation(s) and the costs for such verification/investigation shall be borne by the Company.

For determining the amount of admissible claim, applicable taxes prevailing at the time of the claim will be considered as part of claim amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Sum Insured.

4. TPA to Pay or Reject

The TPA where appointed, shall process and communicate rejection, if a claim is found to be not admissible under this Policy as authorized by the Company. However all decisions shall be the responsibility of the Company.

5. Representation against Rejection

Where rejection is communicated, the Insured/Insured Person, may if so desired, represent to the Company within 15 days for reconsideration of the decision.

6. Condition Precedent

Completed claim forms and documents must be furnished to the Company within the stipulated timelines. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if the Insured can satisfy the Company that it was not reasonably possible for the Insured to submit/give proof within such time.

The due intimation, submission of documents and compliance with requirements by Insured/Insured Person as mentioned above shall be essential failing which Company/TPA shall not be bound to entertain a claim.

7. Claim Settlement

Wherever a claim has not been settled within the stipulations of the Claims Service Clause above, the Company after payment of agreed compensation shall within a period of maximum 30 days on receipt of final completed set of documents/investigation reports (if applicable) offer settlement of the claim. In the event that the Company decides to reject a claim made under this Policy, the Company shall do so within a period of 30 days of receipt of the final completed set of documents/investigation reports (if applicable), in accordance with the provisions of Protection of Policyholders' Interests Regulations, 2002.

VI. General Conditions

1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements or misrepresentation, mis-description or non-disclosure or suppression of any material particulars as sought to be declared on the Proposal form or if any material information had been withheld in the Proposal Form, personal statement, declaration or other documents, or if a claim is found to be fraudulent or any fraudulent` means or device is used by the Insured/ Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

Material information to be disclosed includes every matter that the Insured/Insured Person knows, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company's decision to accept the risk of insurance and if so on those terms. The Insured must exercise the same duty to disclose those matters to the Company before the renewal, extension, variation, endorsement or reinstatement of the contract.

2. Observance of Terms and Conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy insofar as they relate to anything to be done or complied with by the Insured / Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy.

3. Reasonable Care

The Insured/Insured Person shall take all reasonable steps to safeguard against any Accident or illnesses that may give rise to any claim under this Policy.

4. Notice of Charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured/Insured Person or his/her nominees or his/her legal representative or to the Hospital/Nursing Home, as the case may be, of any benefit under the Policy shall in all cases be a full, valid and an effectual discharge by the Company.

5. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument in writing and signed by the Company shall be deemed to be part of this Policy and shall have effect accordingly.

6. Electronic Transactions

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of this Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured/Insured Person.

7. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured/Insured Person's rights or recovery thereof against any person or organization, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured/Insured Person's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. This clause does not apply to benefit sections.

8. Contribution

If there shall be existing any other insurance covering the same Insured/Insured Person whether effected by the Insured/Insured Person or not and If the Claim amount exceeds the Sum Insured under the Policy after considering the deductible or Co-pay, the Company shall not be

liable to pay or contribute more than its ratable proportion of Claim. This clause does not apply where Claim amount is not exceeding the Sum Insured and/or to benefit sections under this Policy. Insured Person has the right to choose the Insurer by who Claim to be settled.

11. Fraudulent Claims

If any claim 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/Insured Person or anyone acting on his / her behalf to obtain any benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons, all sums paid under this Policy shall be repaid to the Company by all Insured Persons who shall be jointly liable for such repayment.

12. Cancellation/Termination

The Company may at any time, cancel this Policy, on grounds of misrepresentation, fraud, non disclosure of material fact as sought to be declared on the proposal form or non co-operation by the insured, by giving 15 days notice in writing by Registered Post. Notice to the Insured/Insured Person will be sent at his/her last known address. The Company shall not be liable to repay the premium for the unexpired term.

The Insured/Insured Person may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales.

Period On Risk	Rate of Premium Refunded
Up to 1 month	75% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	25% of annual rate
Exceeding six months upto 365 days	Nil

An individual policy with a single Insured shall automatically terminate in case of death of the Policyholder. In case of an individual Policy with multiple Insured Person and incase of a floater, the Policy shall continue to be in force for the remaining members of the family upto the expiry of current Policy Period. The Policy may be renewed on an application by another adult Insured Person under the Policy, whenever such is due.

Minimum premium of Rs 50 per policy will be retained by the Company towards administrative charges.

13. Free-look Cancellation

A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. The Insured has the option of cancelling the Policy stating the

reasons for cancellation, if he has any objections to any of the terms and conditions. The Company shall refund the premium paid after adjusting the amounts spent on stamp duty charges and proportionate risk premium. Cancellation will be allowed only if there are no claims paid or reported under the Policy. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not available at the time of renewal of the Policy. Minimum premium shall not apply for free look cancellations.

14. Place/Currency

No claim shall be payable under this Policy for any treatment or expenses outside India. All claims shall be payable in India and in Indian Rupees only.

15. Income Tax benefit

Premium paid under the Policy shall be eligible for benefits under the Income Tax laws prevailing from time to time.

16. Law Applicable

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim thereunder.

17. If a claim is rejected or partially settled and is the not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and liability of the Company extinguished and shall not be recoverable thereafter.

19. Renewal

i. The Company shall not be bound to give notice that renewal is due.
ii. If the Insured desires renewal he/she shall apply to the Company for the same prior to expiry of the Policy Period of Insurance.

iii. Renewals are deemed to be continuous when received within a period of 30 days from the date of expiry of last policy, subject however, to the effective policy inception date being reckoned from such period when the renewal premium is received by the Company.

iv. Policy would be considered as a fresh policy if there would be break of thirty or more days between the previous policy expiry date and current policy start date.

v. The Company shall not be liable for any claim arising out of an ailment suffered or hospitalisation commencing during the period between the expiry of previous policy and date of commencement of subsequent Policy. Any disease/ condition

contracted in the break in period will not be covered and will be treated as Pre-existing condition.

vi. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company.

vii. In case of floater Policies, where dependent child crosses age 18 years, renewal can be done in a separate Policy under the same Product or any other available Products with continuity benefits.

viii. Policy shall be ordinarily renewable for lifetime unless:
   a. any fraud, non cooperation, misrepresentation or suppression of material facts as sought to be declared on the Proposal form by the Insured or on his behalf is found either in obtaining insurance or subsequently in relation thereto or,
   b. the Company has discontinued issue of the particular type of Policy, in which event the Insured shall have the option of renewal under any similar Policy being issued by the Company; provided however, benefits payable shall be subject to the terms contained in such other Policy. Such modification or revision of the terms and conditions of the Product shall be intimated to you 3 months in advance along with reasons of modification and revision

ix. Based on the experience of the Product, Premium, terms and conditions may be revised subject to prior approval of Insurance Regulatory and Development Authority. Such revision shall be intimated to you 3 months in advance with an option of renewal under any similar Policy being issued by Us. However, benefits payable shall be subject to the terms contained in such other Policy. Individual Claims experience loading is not applicable under the Policy.

20. Continuity Benefits

For Roll Over Cases (Portability Policies) Continuity benefits shall be offered to all Insured/Insured Persons in accordance to IRDA circular from time to time.

Portability benefits are not automatically applicable under the Policy unless application for portability has been specifically made and subsequently accepted by the Company.

Where the product is offered to the customers of a specific institution, with which the Company has a tie up, continuity of benefits will be provided under the same or similar policies available with the Insurer during such period in the event that such tie-up has been discontinued.

21. Pre-acceptance Medical Test Requirement

Medical tests not required for individuals up to 65 years, however based on the declarations on the proposal form medical tests may be carried out on a case to case basis.
In case of accepted proposals, the Company shall reimburse 50% of the pre-acceptance medical test costs. (on our pre agreed rates with the network provider

22. Medical Underwriting

Proposers having medical history are subject to Medical Underwriting by the Company. We reserve the right to accept such proposals on standard terms/Decline/Accept with exclusion or Premium loading (up to maximum of 100% on basic Premium). These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us.

23. Endorsements: Following type of endorsement are permissible under the Policy.

Premium Bearing

- Addition of member – Newly married spouse or New born baby permissible at Renewal
- Policy cancellation

Non Premium Bearing

- Address change
- Corrections – Names, address etc
- Change of Occupation

Above list is indicative.

24 Customer Support

You can Contact us on

HDFC ERGO General Insurance Co. Ltd.

D-301, 3 rd Floor, Eastern Business District (Magnet Mall).

LBS Marg, Bhandup (West)

Mumbai - 400078

Toll Free :1800 2 700 700 (Accessible from India only)

Phone (UAN) :1860 2000 700 (Local charges applicable)

Fax (UAN) : 1860 2000 600 (Local charges applicable)

HDFC ERGO General Insurance

Email :healthclaims@hdfcergo.com

25 Grievances Redressal Procedure

At HDFC ERGO General Insurance, we are committed to serve our customers to their satisfaction by providing fast, fair and friendly services at all times.

However, should a customer feel that our services need improvement and wish to lodge your feedback / complaint, you may:

- Call our 24X7 Toll free number 1800-2700-700 from any Landline & Mobile or 1800-226-226 from MTNL or BSNL Phone.
- For lodging a complaint online, email us to our customer service desk at care@hdfcergo.com.

After investigating the matter internally, we will send our response within a period of 10 days.

In case the resolution is likely to take longer time, we will inform you of the same through an interim reply.

Escalation Level 1

For lack of a response or if the response provided does not meet your expectation, you can write to: grievance@hdfcergo.com

After examining the matter, final response would be conveyed within a period of 15 days from the date of receipt of your complaint on this e-mail id.

Escalation Level 2

In case, you are not satisfied with the decision/resolution of the above office, or have not received any response within 15 days, you may write to: cgo@hdfcergo.com

Escalation Level 3

If after following Escalation Level 1 and 2 as stated above your issue remains unresolved, you may approach the Insurance Ombudsman for Redressal.

Contact Details of Insurance Ombudsman

Names of Ombudsman and Addresses of Ombudsmen Centres
Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C. U. Shah College, Ashram Road, **AHMEDABAD** - 380 014. Tel.: 079 - 27545441 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in

HDFC ERGO General Insurance

Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR** - 751 009. Tel.: 0674 - 2596455 / 2596003 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI** - 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Near Panbazar Overbridge, S. S. Road, **GUWAHATI** - 781 001 (ASSAM). Tel.: 0361 - 2132204 / 5 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL** (M.P.) - 462 003. Tel.:- 0755 - 2769201 / 9202 Fax : 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in
Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building, Sector 17 - D, CHANDIGARH - 160 017. Tel.: 0172 - 2706468 / 2705861 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, NEW DELHI - 110 002. Tel.: 011 - 23237539 / 23232481 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD - 500 004. Tel : 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in
Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, ERNAKULAM - 682 015. Tel.: 0484 - 2358759 / 2359338

HDFC ERGO General Insurance

Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in
Office of the Insurance Ombudsman, Jeevan Bhawan, Phase - 2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW - 226 001. Tel : 0522 - 2231331 / 2231330 Fax : 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, JAIPUR - 302 005 Tel : 0141 - 2740363 Email: bimalokpal.jaipur@gbic.co.in
Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg. JP Nagar, 1st Phase, BENGALURU - 560 025. Tel No: 080 - 22222049 / 22222048 Email: bimalokpal.bengaluru@gbic.co.in
Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C. R. Avenue, KOLKATA - 700 072. Tel : 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in
Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz (W), MUMBAI - 400 054. Tel : 022 - 26106928 / 26106552 Fax : 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in
Office of the Insurance Ombudsman, 2nd Floor, Jeevan Darshan, N. C. Kelkar Road, Narayanpet, PUNE - 411 030. Tel: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in
Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Dist. Gautam Buddh Nagar, NOIDA (U.P) - 201 301. Tel.: 0120 - 2514250 / 2514251 / 2514253

Email: bimalokpal.noida@gbic.co.in
Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, PATNA - 800 006. Email: bimalokpal.patna@gbic.co.in
OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL Smt. Ramma Bhasin, Secretary General, Shri Y.R. Raigar, Secretary, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), MUMBAI - 400 054 Tel : 022 - 26106889 / 6671 Fax : 022 - 26106949 Email- inscoun@gbic.co.in

26. IRDA Regulations: This Policy is subject to Regulations of IRDA (Protection Of Policyholder's Interest) Regulations, 2002 as amended from time to time.