Take it easy!

HDFC ERGO GENERAL INSURANCE

GROUP MEDICLAIM POLICY WORDING

1. Preamble:

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.

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 TREATMENTs 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.

1.1. 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:

- the treatment is such that it necessitates hospitalisation and the procedure involves specialised infrastructural facilities available only in HOSPITALS; and
- due to technological advances hospitalisation is required for less than twenty-four (24) hours.

1.2. 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 item1.2 above.

1.3. 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.

1.4. DOMICILIARY HOSPITALISATION EXPENSES is hereby covered subject to the following exclusions:

1.4.1. Expenses incurred for pre and post HOSPITAL treatment; and

1.4.2. Expenses incurred for treatment for any of the following DISEASEs:

1.4.2.1. Asthma;
1.4.2.2. Bronchitis;
1.4.2.3. Chronic Nephritis and Nephrotic Syndrome;
1.4.2.4. Diarrhoea and all type of Dysenteries including Gatro-enterities;
1.4.2.5. Diabetes Mellitus Insipidus;
1.4.2.6. Epilepsy;
1.4.2.7. Hypertension;
1.4.2.8. Influenza, Cough and cold;
1.4.2.9. All Psychiatric or Psychosomatic Disorders;
1.4.2.10. Pyrexia of unknown origin for less than 10 days;
1.4.2.11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
1.4.2.12. 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.

1.5. 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 means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

2.3. ANY ONE ILLNESS means continuous period of illness and it includes relapse within 45 days from date of last consultation with the HOSPITAL / NURSING HOME where treatment may have been taken.

2.4. 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.

2.5. AYUSH Coverage - Insurers may provide coverage to non-allopathic treatments' provided the treatment has been undergone in a Govt Hospital or in any institute recognized by govt and/or accredited by Quality Council of India/National Accreditation Board on Health.

2.6. "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.

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

2.8. 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

b. EXTERNAL CONGENITAL ANOMALY which is in the visible and accessible parts of the body.

2.9. 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 of sum insured.

2.10. 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 claim amount. A co-payment does not reduce the Sum Insured.

2.11. 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.

2.12. DAY CARE TREATMENT 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 hrs because o f technological advancement, and

b. Which would have otherwise required a hospitalization o f more than 24 hours.

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

2.13. 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 in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

2.14. 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.

2.15. 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.

2.16. DISCLOSURE TO INFORMATION NORM 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.

2.17. 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

2.18. 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.

2.19. EMERGENCY CARE means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment o f the insured person's health

2.20. 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.

2.21. GRACE PERIOD means the specified period o f time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss o f continuity benefits such as waiting periods and coverage of p re existing diseases. Coverage is not available for the period for which no premium is received

2.22. HOSPITAL 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 under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. has qualified nursing staff under its employment round the clock;

b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

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 makes these accessible to the insurance company's authorized personnel

2.23. HOSPITALISATION Means admission in a Hospital for a minimum period o f 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period o f less than 24 consecutive hours

2.24. ILLNESS means a sickness or a disease or pathological condition leading to the impairment o f normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. ACUTE CONDITION - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

b. CHRONIC CONDITION - 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.

2.25. 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.

2.26. 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

2.27. INPATIENT CARE means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

2.28. 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

2.29. 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

2.30. MEDICAL ADVISE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.31. 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.

2.32. 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 licence.

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.

2.33. MEDICALLY NECESSARY Medically necessary treatment is defined as any

treatment, tests, medication, or stay in hospital or part o f a stay in hospital which

a. is required for the medical management o f the illness or injury suffered by the insured

b. must not exceed the level o f care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity

c. must have been prescribed by a medical practitioner,

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India

2.34. 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.

2.35. NON- NETWORK means any hospital, day care centre or other provider that is not part of the network.

2.36. NEWBORN BABY means those babies born to you and your spouse during the Policy Period Aged between 1 day and 90 days, both days inclusive.

2.37. 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.

2.38. 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.

2.39. PER OCCURRENCE LIMIT means maximum amount that can be reimbursed for ANY ONE ILLNESS covered under the scope of the policy.

2.40. 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.

2.41. POLICYHOLDER means the entity or person named as such in the Schedule.

2.42. 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

2.43. PRE-EXISTING DISEASE: Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer

2.44. 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

2.45. POST-HOSPITALIZATION MEDICAL EXPENSES means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.46. 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.

2.47. REASONABLE AND CUSTOMARY CHARGES means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

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 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

2.50. SPOUSE means an INSURED PERSON'S husband or wife who is recognised as such by the laws of the jurisdiction in which they reside.

2.51. 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.

2.52. 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.

2.53. 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.

2.54. THIRD PARTY ADMINISTRATORS OR TPA means any person who is licensed under the IRDA (Third party administrators- Health Services) Regulation, 2001 by the authority and is engaged for a fee or remuneration by an insurance company for the purpose of providing health services

2.55. 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 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 anomaly , fistula in anus, piles, Sinusitis and related disorders are not payable. If these DISEASEs (other than congenital internal anomaly) 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 anomaly before inception of policy, the same will be treated as a PRE-EXISTING DISEASE.

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, Tetrology 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 Lymphadinopathy 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 2.35 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. The Company may consider the delay in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit.

e. Insurer will only make payment to or at the insured's direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to the company of having incurred the expenses, this person will be deemed to be authorised by the insured to receive the concerned payment. In the event of the death of an Insured Person, the Company will make payment to the Nominee.

f. 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.

g. 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.

h. 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.

i. If, at the time when any claim arises under this policy, there is in existence two or more policies are taken by POLICYHODER / 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.

j. 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. 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.

   PERIOD ON RISK RATE OF PREMIUM TO BE CHARGED
   Upto one month 1/4 of the annual rate
   Upto three months ½ of the annual rate
   Upto six months 3/4 of the annual rate
   Exceeding six months Full annual rate

   The Company may cancel this Policy on grounds of misrepresentation, fraud, non disclosure of material facts, non cooperation by POLICY HOLDER, INSURED PERSON or anyone acting on POLICY HOLDER's behalf or on the behalf of INSURED PERSON. Such cancellation of the policy will be from inception date or the renewal date (as the case may be) upon 30 days notice and by sending an endorsement in this regard at your address shown in the schedule without refund of any premium

k. 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 1st Floor, HUL House, H.T. Parekh Marg, 165-166 Backbay Reclamation, Churchgate, Mumbai- 400020.

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.

l. 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.

m. This policy shall ordinarily be renewable for life only by mutual consent except for grounds such as mis-representation, fraud, moral hazard or non co-operation by the Insured and subject to payment in advance of the total premium at the rate in force at the time of renewal and subject to the policy is renewed within the Grace period of 30 days from date of Expiry. Unless renewed as herein provided, this policy shall automatically terminate at the expiry of the period for which premium has already been paid.

n. All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

o. This Policy shall be governed by the laws of India and the courts in Mumbai alone shall have jurisdiction in any dispute arising hereunder.

p. 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.

q. 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.

r. 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.

s. Portability: Individual members including the family members covered under this group health insurance policy shall have the right to migrate from such group policy to a suitable individual health insurance policy or a family floater policy offered by the Company only in cases of the employee leaving the group on account of retirement/resignation.

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. Any changes in the network will be informed to the policyholders by TPA.

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 other than those mentioned in the updated list of network hospitals.

c. The claims eligibility protocol shall be as follows:

i. All hospitalization events need to be pre-authorized by TPA.
ii. Pre-authorization needs to be done at least 48 hours prior to a planned hospitalization
iii. For emergency hospitalizations, pre-authorization should be done within 24 hours of admission
iv. The insured person may choose to seek hospitalization either at a network or non-network hospital
v. For network hospitalizations, the insured will be eligible for credit facilities subject to fulfilling the eligibility criteria as per the policy
vi. In the event of complications during hospitalization or a change in course of treatment, the insured should notify TPA accordingly.
vii. In the event of non-notification, the insured's claim for the unauthorized treatment is liable to be rejected by the insurer.
viii. For credit hospitalizations, all expenses that are excluded from the benefits are payable by the insured at discharge.
ix. For credit hospitalizations, the bills/supporting documents will be forwarded to TPA by the hospital/nursing home.
x. Pre and post hospitalization bills will be forwarded by the insured to TPA
xi. For non-credit hospitalizations, the bills will be settled by the insured and sent along with supporting documents to TPA
xii. All original documents will be supported by a claim form
xiii. Reimbursement is subject to receiving all relevant documents and a completed claim form
xiv. 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.c.1. 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.c.2. 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

GROUP MEDICLAIM POLICY WORDING

d. List of Claims Documents: The Insured Person shall obtain and furnish the Company with following documents and shall also give the Company such additional information and assistance as the Company may need to process the claim.

- Original Claim Form
- Police FIR, if accident is reported to Police
- Discharge Card, Medical papers, pathology reports, X-ray reports, as applicable
- Doctor's prescription and line of treatment suggested
- Original Bills, Receipts and cash memos duly signed
- Attending Physician's statement

e. For any claim related query, intimation of claim and submission of claim related documents, the company may be contacted on,

Address 1:
HDFC ERGO General Insurance Company Limited.,
5th floor, Tower 1, Stellar IT Park, C-25, Sector-62,
Noida-201301, Uttar Pradesh

Address 2:
HDFC ERGO General Insurance Company Limited.,
6th floor, MBC Tower, Old No.90, New No.199,
Luz Church Road, Mylapore, Chennai - 600 004, Tamil Nadu

Toll free : 18002001999 & 18002700700
Fax : 18602000600
Email address: healthclaims@hdfcergo.com & preauth@hdfcergo.com

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 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

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
Shri B.N. Mishra, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR** - 751 009. Tel.: 0674-2596455/2596003 Fax: 0674-2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Shri Virander Kumar, Office of the Insurance Ombudsman, Fathima 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
Shri Raj Kumar Srivastava, 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
Shri Manik Sonawane 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

GROUP MEDICLAIM POLICY WORDING

Smt. Sandhya Baliga, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI** - 110 002. Tel.: 011-23237539/23232481 Fax: 011-23230858 Email: bimalokpal.delhi@gbic.co.in
Shri G. Rajeswara Rao, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD** - 500 004. Tel : 040-65504123/23312122 Fax: 040-23376599 Email: bimalokpal.hyderabad@gbic.co.in
Shri P.K.Vijayakumar, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, **ERNAKULAM** - 82 015. Tel.: 0484-2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@gbic.co.in
Shri N.P. Bhagat, 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
Shri A. K. Jain, Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, **JAIPUR** – 302005 Tel : 0141-2740363 Email: bimalokpal.jaipur@gbic.co.in
Shri M. Parshad, Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg. JP Nagar, 1st Phase, **BENGALURU** – 560025. Tel No: 080-22222049/ 22222048 Email: bimalokpal.bengaluru@gbic.co.in
Shri K.B. Saha, 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
Shri A. K. Dasgupta, 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
Shri A. K. Sahoo, 2nd Floor, Jeevan Darshan, N. C. Kelkar Road, Narayanpet, **PUNE** – 411030. Tel: 020-32341320 Email: bimalokpal.pune@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

Appendix I: Day Care Procedure

Day Care Procedures will include following Day Care Surgeries & Day Care Treatments

Microsurgical operations on the middle ear

1. Stapedectomy
2. Revision of a stapedectomy
3. Other operations on the auditory ossicles
4. Myringoplasty (Type -I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6. Revision of a tympanoplasty
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract
39. Retinal Detatchment

Operations on the skin & subcutaneous tissues

40. Incision of a pilonidal sinus
41. Other incisions of the skin and subcutaneous tissues
42. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
43. Local excision of diseased tissue of the skin and subcutaneous tissues
44. Other excisions of the skin and subcutaneous tissues
45. Simple restoration of surface continuity of the skin and subcutaneous tissues
46. Free skin transplantation, donor site
47. Free skin transplantation, recipient site
48. Revision of skin plasty
49. Other restoration and reconstruction of the skin and subcutaneous tissues
50. Chemosurgery to the skin
51. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

52. Incision, excision and destruction of diseased tissue of the tongue
53. Partial glossectomy
54. Glossectomy
55. Reconstruction of the tongue
56. Other operations on the tongue

Operations on the salivary glands & salivary ducts

57. Incision and lancing of a salivary gland and a salivary duct
58. Excision of diseased tissue of a salivary gland and a salivary duct
59. Resection of a salivary gland

60. Reconstruction of a salivary gland and a salivary duct
61. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

62. External incision and drainage in the region of the mouth, jaw and face
63. Incision of the hard and soft palate
64. Excision and destruction of diseased hard and soft palate
65. Incision, excision and destruction in the mouth
66. Plastic surgery to the floor of the mouth
67. Palatoplasty
68. Other operations in the mouth under general/spinal anesthesia

Operations on the tonsils & adenoids

69. Transoral incision and drainage of a pharyngeal abscess
70. Tonsillectomy without adenoidectomy
71. Tonsillectomy with adenoidectomy
72. Excision and destruction of a lingual tonsil
73. Other operations on the tonsils and adenoids under general/spinal anesthesia

Trauma surgery and orthopaedics

74. Incision on bone, septic and aseptic
75. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76. Suture and other operations on tendons and tendon sheath
77. Reduction of dislocation under GA
78. Arthroscopic knee aspiration

Operations on the breast

79. Incision of the breast
80. Operations on the nipple

Operations on the digestive tract

81. Incision and excision of tissue in the perianal region
82. Surgical treatment of anal fistulas
83. Surgical treatment of haemorrhoids
84. Division of the anal sphincter (sphincterotomy)
85. Other operations on the anus
86. Ultrasound guided aspirations
87. Sclerotherapy

Operations on the female sexual organs

88. Incision of the ovary
89. Insufflation of the Fallopian tubes
90. Other operations on the Fallopian tube
91. Dilatation of the cervical canal
92. Conisation of the uterine cervix
93. Other operations on the uterine cervix
94. Incision of the uterus (hysterotomy)
95. Therapeutic curettage
96. Culdotomy
97. Incision of the vagina
98. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99. Incision of the vulva
100. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

101. Incision of the prostate
102. Transurethral excision and destruction of prostate tissue
103. Transurethral and percutaneous destruction of prostate tissue
104. Open surgical excision and destruction of prostate tissue
105. Radical prostatovesiculectomy
106. Other excision and destruction of prostate tissue
107. Operations on the seminal vesicles
108. Incision and excision of periprostatic tissue
109. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

110. Incision of the scrotum and tunica vaginalis testis
111. Operation on a testicular hydrocele
112. Excision and destruction of diseased scrotal tissue
113. Plastic reconstruction of the scrotum and tunica vaginalis testis
114. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

115. Incision of the testes
116. Excision and destruction of diseased tissue of the testes
117. Unilateral orchidectomy
118. Bilateral orchidectomy
119. Orchidopexy
120. Abdominal exploration in cryptorchidism
121. Surgical repositioning of an abdominal testis
122. Reconstruction of the testis
123. Implantation, exchange and removal of a testicular prosthesis
124. Other operations on the testis

Operations on the spermatic cord, epididymis und ductus deferens

125. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126. Excision in the area of the epididymis
127. Epididymectomy
128. Reconstruction of the spermatic cord
129. Reconstruction of the ductus deferens and epididymis
130. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

131. Operations on the foreskin
132. Local excision and destruction of diseased tissue of the penis
133. Amputation of the penis
134. Plastic reconstruction of the penis
135. Other operations on the penis

Operations on the urinary system

136. Cystoscopical removal of stones

Other Operations

137. Lithotripsy
138. Coronary angiography
139. Haemodialysis
140. Radiotherapy for Cancer
141. Cancer Chemotherapy
142. Renal Biopsy
143. Bone Marrow Biopsy
144. Liver Biopsy

APPENDIX-II

Sr. No.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE	
1.	Anne French Charges	Not Payable
2.	Baby Charges (unless Specified/ indicated)	Not Payable
3.	Baby Food	Not Payable
4.	Baby Utilites Charges	Not Payable
5.	Baby Set	Not Payable
6.	Baby Bottles	Not Payable
7.	Bottle	Not Payable
8.	Brush	Not Payable
9.	Cosy Towel	Not Payable
10.	Hand Wash	Not Payable
11.	Moisturiser Paste Brush	Not Payable
12.	Powder	Not Payable
13.	Razor	Payable
14.	Towel	Not Payable
15.	Shoe Cover	Not Payable
16.	Beauty Services	Not Payable
17.	Belts/ Braces	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
18.	Buds	Not Payable
19.	Barber Charges	Not Payable
20.	Caps	Not Payable

GROUP MEDICLAIM POLICY WORDING

21.	Cold Pack/hot Pack	Not Payable
22.	Carry Bags	Not Payable
23.	Cradle Charges	Not Payable
24.	Comb	Not Payable
25.	Disposables Razors Charges (For Site Preparations)	Payable
26.	Eau-de-cologne / Room Freshners	Not Payable
27.	Eye Pad	Not Payable
28.	Eye Sheild	Not Payable
29.	Email/ Internet Charges	Not Payable
30.	Food Charges (other Than Patient's Diet Provided By Hospital)	Not Payable
31.	Foot Cover	Not Payable
32.	Gown	Not Payable
33.	Leggings	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
34.	Laundry Charges	Not Payable
35.	Mineral Water	Not Payable
36.	Oil Charges	Not Payable
37.	Sanitary Pad	Not Payable
38.	Slippers	Not Payable
39.	Telephone Charges	Not Payable
40.	Tissue Paper	Not Payable
41.	Tooth Paste	Not Payable
42.	Tooth Brush	Not Payable
43.	Guest Services	Not Payable
44.	Bed Pan	Not Payable
45.	Bed Under Pad Charges	Not Payable
46.	Camera Cover	Not Payable
47.	Care Free	Not Payable
48.	Cliniplast	Not Payable
49.	Crepe Bandage	Not Payable/ Payable by the patient
50.	Curapore	Not Payable
51.	Diaper of Any Type	Not Payable
52.	Dvd, Cd Charges	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
53.	Eyelet Collar	Not Payable
54.	Face Mask	Not Payable
55.	Flexi Mask	Not Payable
56.	Gause Soft	Not Payable
57.	Gauze	Not Payable
58.	Hand Holder	Not Payable
59.	Hansaplast/ Adhesive Bandages	Not Payable
60.	Lactogen/ Infant Food	Not Payable
61.	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered

	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
62.	Weight Control Programs/ Supplies/ Services	Exclusion in policy unless otherwise specified
63.	Cost Of Spectacles/ Contact Lenses/ Hearing Aids Etc.,	Exclusion in policy unless otherwise specified
64.	Dental Treatment Expenses That Do Not Require Hospitalisation	Exclusion in policy unless otherwise specified
65.	Hormone Replacement Therapy	Exclusion in policy unless otherwise specified
66.	Home Visit Charges	Exclusion in policy unless otherwise specified
67.	Infertility/ Subfertility/ Assisted Conception Procedure	Exclusion in policy unless otherwise specified
68.	Obesity (including Morbid Obesity) Treatment	Exclusion in policy unless otherwise specified
69.	Psychiatric & Psychosomatic Disorders	Exclusion in policy unless otherwise specified
70.	Corrective Surgery For Refractive Error	Exclusion in policy unless otherwise specified
71.	Treatment Of Sexually Transmitted Diseases	Exclusion in policy unless otherwise specified
72.	Donor Screening Charges	Exclusion in policy unless otherwise specified
73.	Admission/Registration Charges	Exclusion in policy unless otherwise specified
74.	Hospitalisation For Evaluation/ Diagnostic Purpose	Exclusion in policy unless otherwise specified
75.	Expenses For Investigation/ Treatment Irrelevant to the Disease for which Admitted or Diagnosed	Not Payable- Exclusion in policy unless otherwise specified
76.	Any Expenses When the Patient is Diagnosed with Retro Virus + or Suffering from /hiv/ Aids etc is Detected/ Directly or Indirectly	Not payable as per HIV/AIDS exclusion
77.	Stem Cell Implantation/ Surgery	Not Payable except Bone Marrow Transplantation where covered by policy
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES	
78.	Ward And Theatre Booking Charges	Payable under OT Charges, not payable separately
79.	Arthroscopy & Endoscopy Instruments	Rental charged by the hospital payable. Purchase of Instruments not payable.
80.	Microscope Cover	Payable under OT Charges, not separately
81.	Surgical Blades,harmonic Scalpel, shaver	Payable under OT Charges, not separately
82.	Surgical Drill	Payable under OT Charges, not separately

Take it easy!

HDFC ERGO GENERAL INSURANCE

GROUP MEDICLAIM POLICY WORDING

83.	Eye Kit	Payable under OT Charges, not separately
84.	Eye Drape	Payable under OT Charges, not separately
85.	X-ray Film	Payable under Radiology Charges, not as consumable
86.	Sputum Cup	Payable under Investigation Charges, not as consumable
87.	Boyles Apparatus Charges	Part of OT Charges, not seperately
88.	Blood Grouping And Cross Matching of Donors Samples	Part of Cost of Blood, not payable
89.	Savlon	Not Payable - Part of Dressing Charges
90.	Band Aids, Bandages, Sterlile Injections, Needles, Syringes	Not Payable - Part of Dressing Charges
91.	Cotton	Not Payable - Part of Dressing Charges
92.	Cotton Bandage	Not Payable - Part of Dressing Charges
93.	Micropore/ Surgical Tape	Not Payable- Payable by the patient when prescribed, otherwise included as Dressing Charges
94.	Blade	Not Payable
95.	Apron	Not Payable - Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
96.	Torniquet	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
97.	Ortho bundle, Gynaec Bundle	Part of Dressing Charges
98.	Urine Container	Not Payable
	ELEMENTS OF ROOM CHARGE	
99.	Luxury Tax	Actual tax levied by government is payable Part of room charge for sub limits
100.	Hvac	Part of room charge not payable separately
101.	House Keeping Charges	Part of room charge not payable separately
102.	Service Charges Where Nursing Charge also Charged	Part of room charge not payable separately
103.	Television & Air Conditioner Charges	Payable under room charges not if separately levied
104.	Surcharges	Part of room charge not payable separately
105.	Attendant Charges	Not Payable - Part of Room Charges
106.	Im Iv Injection Charges	Part of nursing charges, not payable
107.	Clean Sheet	Part of Laundry/ Housekeeping not payable separately
108.	Extra Diet of Patient (other than that which forms part of Bed charge)	Patient Diet provided by hospital is payable
109.	Blanket/ warmer Blanket	Not Payable- part of room charges

	ADMINISTRATIVE OR NON-MEDICAL CHARGES	
110.	Admission Kit	Not Payable
111.	Birth Certificate	Not Payable
112.	Blood Reservation Charges and Ante Natal Booking Charges	Not Payable
113.	Certificate Charges	Not Payable
114.	Courier Charges	Not Payable
115.	Convenyance Charges	Not Payable
116.	Diabetic Chart Charges	Not Payable
117.	Documentation Charges/ Administrative Expenses	Not Payable
118.	Discharge Procedure Charges	Not Payable
119.	Daily Chart Charges	Not Payable
120.	Entrance Pass/Visitors Pass Charges	Not Payable
121.	Expenses Related to Prescription on Discharge	To be claimed by patient under Post Hosp where admissible
122.	File Opening Charges	Not Payable
123.	Incidental Expenses/Misc. Charges (not Explained)	Not Payable
124.	Medical Certificate	Not Payable
125.	Maintainance Charges	Not Payable
126.	Medical Records	Not Payable
127.	Preparation Charges	Not Payable
128.	Photocopies Charges	Not Payable
129.	Patient Identification Band/ Name Tag	Not Payable
130.	Washing Charges	Not Payable
131.	Medicine Box	Not Payable
132.	Mortuary Charges	Payable upto 24 hrs, shifting charges not payable
133.	Medico Legal Case Charges (mlc Charges)	Not Payable
	EXTERNAL DURABLE DEVICES	
134.	Walking Aids Charges	Not Payable
135.	Bipap Machine	Not Payable
136.	Commode	Not Payable
137.	Cpap/ Capd Equipments	Device not Payable
138.	Infusion Pump - Cost	Device not Payable
139.	Oxygen Cylinder(for Usage Outside the Hospital)	Not Payable
140.	Pulseoxymeter Charges	Device not Payable
141.	Spacer	Not Payable
142.	Spirometre	Device not Payable
143.	Spo2 Probe	Device not Payable
144.	Nebulizer Kit	Device not Payable
145.	Steam Inhaler	Not Payable
146.	Armsling	Not Payable
147.	Thermometer	Not Payable (paid by patient)
148.	Cervical Collar	Not Payable
149.	Splint	Not Payable
150.	Diabetic Foot Wear	Not Payable
151.	Knee Braces (Long/ Short/ Hinged)	Not Payable
152.	Knee Immobilizer/ shoulder Immobilizer	Not Payable

GROUP MEDICLAIM POLICY WORDING

153.	Lumbo Sacral Belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
154.	Nimbus Bed or Water or Air Bed Charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
155.	Ambulance Collar	Not Payable
156.	Ambulance Equipment	Not Payable
157.	Microsheild	Not Payable
158.	Abdominal Binder	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
159.	Betadine\hydrogen Peroxide\spirit\ dettol\savlon\Disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
160.	Private Nurses Charges- Special Nursing Charges	Post hospitalization nursing charges not Payable
161.	Nutrition Planning Charges - Dietician Charges - Diet Charges	Patient Diet provided by hospital is payable
162.	Alex Sugar Free	Payable -Sugar free variants of admissable medicines are not excluded
163.	Creams Powders Lotions (toileteries are not Payable, only Prescribed Medical Pharmaceuticals Payable)	Payable when prescribed
164.	Digene Gel/ Antacid Gel	Payable when prescribed
165.	Ecg Electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
166.	Gloves	Sterilized Gloves payable/ unsterilized gloves not payable
167.	HIV Kit	Payable - payable Pre operative screening
168.	Listerine/ Antiseptic Mouthwash	Payable when prescribed
169.	Lozenges	Payable when prescribed
170.	Mouth Paint	Payable when prescribed
171.	Nebulisation Kit	If used during hospitalization is payable reasonably
172.	Neosprin	Payable when prescribed
173.	Novarapid	Payable when prescribed
174.	Volini Gel/ Analgesic Gel	Payable when prescribed
175.	Zytee Gel	Payable when prescribed
176.	Vaccination Charges	Routine Vaccination not Payable/ Post Bite Vaccination Payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
177.	AHD	Not Payable - Part of Hospital's internal Cost
178.	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
179.	Scrub Solution/sterillium	Not Payable - Part of Hospital's internal Cost
	OTHERS	
180.	Vaccine Charges for Baby	Not Payable
181.	Aesthetic Treatment/ Surgery	Not Payable
182.	TPA Charges	Not Payable
183.	Visco Belt Charges	Not Payable
184.	Any Kit with no Details Mentioned [delivery Kit, Ortho kit, Recovery Kit, etc]	Not Payable
185.	Examination Gloves	Not Payable
186.	Kidney Tray	Not Payable
187.	Mask	Not Payable
188.	Ounce Glass	Not Payable
189.	Outstation Consultant's/ Surgeon's Fees	Not Payable
190.	Oxygen Mask	Not Payable
191.	Paper Gloves	Not Payable
192.	Pelvic Traction Belt	Should be payable in case of PIVD requiring tractions this is generally not reused
193.	Referal Doctor's Fees	Not Payable
194.	Accu Check (glucometery/ Strips)	Not payable pre hospitalisation or post hospitalisation/Reports and Charts required/ Device not payable
195.	Pan Can	Not Payable
196.	Sofnet	Not Payable
197.	Trolly Cover	Not Payable
198.	Urometer, Urine Jug	Not Payable
199.	Ambulance	Payable- Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
200.	Tegaderm/ Vasofix Safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
201.	Urine Bag	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
202.	Softovac	Not Payable
203.	Stockings	Essential for case like CABG etc. where it should be paid.