GRAMIN AROGYA NIDHI POLICY

PREAMBLE:

WHEREAS the Policyholder named in the Schedule has applied to HDFC ERGO General Insurance Company Limited (hereinafter called "the Company") for the insurance herein contained, the Company agrees subject to:

1. any proposal or other information supplied by or on behalf of the Insured Person:

1.1. disclosing all facts and circumstances known to the Insured Person that are material to the assessment of the risks insured hereby,

And

1.2. forming the basis of this insurance, and

2. the Insured having paid the premium on or before the due date thereof and the same having been realized by the Company;

to grant such insurance to the Insured subject to the terms, conditions, provisions and exclusions set out in this Policy or as contained in any endorsement that may be issued.

DEFINITIONS COMMON

1. **Accident or Accidental** means a sudden, unforeseen, uncontrollable and unexpected physical event to the Insured person or member caused by external, violent and visible means.
2. **Age or Aged** means completed years as at the Commencement Date.
3. **Bodily Injury** means physical, external, Accidental bodily injury occurring suddenly in time and resulting solely and independently of any other cause or any physical defect or infirmity existing before the commencement of Period of Insurance.
4. **Company** means HDFC ERGO General Insurance Company Limited.
5. **Cover Period** means the period during which the benefits under the policy may accrue to the Insured person(s), whose name(s) are specifically appearing in the Schedule of the respective sections of this Policy, beginning from the date of commencement of cover to policy end date (or such date that is agreed upon between the Company and the Policyholder).
6. **Dependent Children** means an unmarried dependent child ordinarily residing with the policyholder between the ages of 3 months and up to and including the age of eighteen (18) years, if in full time education at an educational institution at the time of death, injury or

disablement giving rise to a claim under the Policy. This includes legally adopted children and children from a previous marriage, of an policyholder or the Spouse of an Policyholder. However in cases where the Dependent Child is pursuing education from any accredited institution the maximum age of entry may be extended upto 25 years.

7. 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.

8. 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.

9. Hospital/Nursing Homes means any institution in India established for Medical Treatment which:

   i) Either:

   (a) has been registered and licensed as a hospital with the appropriate local or other authorities competent to register hospitals in the relevant area and is under the constant supervision of a Medical Practitioner and is not, except incidentally, a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution.

   (b) Or

   (i) is under the constant supervision of a Medical Practitioner, and
   (ii) has fully qualified nursing staff (that hold a certificate issued by a recognized nursing council) under its employment in constant attendance , and
   (iii) maintains daily records of each of its patients, and
   (iv) has at least 5 Inpatient beds, and
   (v) has a fully equipped and functioning operation theatre.

10. Illness means sickness or disease that first manifests itself during the *Policy Period* and for which immediate treatment by a Doctor is necessary, but does not include any mental disease, sickness or illness.

11. Policyholder (Proposer) means anyone over the age of eighteen (18) years and aged Sixty Five (65) years old or younger who is specifically named in the Schedule, except when the Company, at its sole discretion, accepts anyone above 65 years and upto 80 years old, for whom premium has been paid and who is identified in the Policy Schedule as an Insured Person.

12. Insured Person (Section I) means a Policyholder and/or the Spouse of a Policyholder who has been identified in the Policy Schedule as an Insured Person.

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13. **Insured Person (Section II)** means a Policyholder and/or, his/her Spouse and/or their Dependent Children who have been identified in the Policy Schedule as an Insured Person.

14. **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.

15. **Policy** means Your statements in the proposal form, this policy wording (including endorsements, if any), any attachments to the policy and the Schedule (as the same may be amended from time to time).

16. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

17. **Premium Installment** means premium payable at a fixed frequency of a month, a quarter, a six month period or any other frequency period agreed to by the Company and the Policy Holder, the period beginning from the Policy Effective Date.

18. **Qualified Nurse** means a person who holds a certificate of a recognized nursing council and who is employed on the recommendations of an attending medical practitioner.

19. **Surgical Operation** 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.

20. **Sickness** means a condition or an ailment affecting the general soundness and health of the Insured's body, but excluding any disease or illness which arises out of or is caused by a condition or defect for which medical treatment was recognized, advised, sought out, or should have reasonably been sought out, or received at any time before the Period of Insurance.

21. **Spouse** means an Policyholder's husband or wife who is recognized as such by the laws of the jurisdiction in which they reside and who does not exceed Sixty Five (65) years of age or less except when the Company, at its sole discretion, accepts anyone above 65 years and upto 80 years old, for whom premium has been paid and who is identified in the Policy Schedule as an Insured Person.

22. **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.

23. **TPA** means the third party administrator that the Company may appoint from time to time and as specified in the Schedule

24. **We/Our/Us** means the **HDFC ERGO General Insurance Company Limited**

25. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

GENERAL CONDITIONS

1. Due Observance :

The due observance and fulfilment of terms and conditions of this policy (which conditions and all endorsements hereon are to be read as part of this Policy) shall so far as they relate to anything to be done or not to be done by any person covered under the policy shall be a condition precedent to any liability of the Company under this policy.

2. The policy, the schedule, the proposal form, riders, endorsements and any memorandum shall constitute the complete contract of insurance. No change or alteration in this policy shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by an endorsement / extension on the policy.

3. Duties and Obligations after Occurrence of an Insured Event :

Upon the happening of any event which may give rise to a claim under this policy the person covered under the policy shall forthwith give notice thereof to the Company. Unless reasonable cause is shown, the person covered under the policy should within one Calendar month after the event which may give rise to a claim under the policy, give written notice to the Company with full particulars of the claim.

4. Notices :

Every notice, communication or intimation required or contemplated under this policy to be given by the person covered under the policy or anyone on his/her behalf in respect of any claim or matter arising under or out of this policy shall be in writing and addressed to the Company's office through which this insurance is effected or the Company's corporate office currently located at

6th floor, Leela Business Park,
Andheri Kurla Road,
Andheri (E) Mumbai 400059

unless otherwise directed by the Company in writing. No such notice, communication or intimation shall be valid unless it contains full particulars of the policy, persons covered under the policy and other details as may be necessary.

5. Fraud:

This policy shall be voidable at the option of the company in the event of mis-representation, mis-description or non-disclosure of any material particular by the policy holder, person insured under the policy or a beneficiary under this policy if he is different from the person insured. Any person who, knowingly and with intent to defraud the

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insurance company or other persons, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which will render the policy voidable at the insurance company's sole discretion and result in a denial of insurance benefits. If a claim is in any respect be fraudulent, or if any fraudulent or false plan, specification, estimate, deed, book, account entry, voucher, invoice or other document, proof or explanation is produced, or any fraudulent means or devices are used by the policyholder, person insured under the policy, beneficiary, claimant or by anyone acting on their behalf to obtain any benefit under this policy, or if any false statutory declaration is made or used in support thereof, or if loss is occasioned by or through the procurement or with the knowledge or connivance of the policyholder, person insured, beneficiary, claimant or other person, then all benefits under this policy stand forfeited.

6. 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 statement or devise, whether by the persons covered under the policy or by any person on their behalf.

7. Proof satisfactory to the Company shall be furnished of all matters upon which a claim is based. Any representative of the Company shall be allowed to examine the persons covered under the policy on the occasion of the alleged injury, disease or disablement whenever and as often as the same may reasonably be required on behalf of the Company and in the event of death to conduct a post mortem examination of the persons covered under the policy and such evidence as required by the Company from time to time shall be furnished within the period of 14 days after demand in writing. Provided that in the case of a claim by death or permanent total disablement under Section I, all sums will be payable only on the delivery of this policy and certificate of insurance appropriately cancelled and discharged.

8. No sum payable under this policy shall carry Interest of any type.

9. Cancellation ;

   This Policy may be cancelled by or on behalf of the Company by giving the Insured at least 30 days written notice and in such event the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period. For the avoidance of doubt, the Company shall remain liable for any claim that was made prior to the date upon which this insurance is cancelled.

   This Policy may be cancelled by the Insured at any time by giving at least 30 days written notice to the Company. The Company will refund premium in accordance with the Short Period Scale below:

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGE

Upto One Month	1/4 of the annual rate
Upto Three Months	1/2 of the annual rate
Upto Six Months	3/4 of the annual rate
Exceeding Six Months	Full annual rate

10. Dispute Resolution:

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

If any dispute or difference shall arise 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 a sole arbitrator to be appointed in writing jointly by the Insured and the Company or if they cannot agree upon a single arbitrator to be appointed within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by the Insured and the Company respectively and the third arbitrator to be appointed by the two arbitrators, which arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act , 1996, as amended from time to time and for the time being in force.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as hereinbefore provided, if Company has disputed liability under or in respect of this Policy.

It is hereby 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 arbitrators of the amount of the loss or damage shall be first obtained.

11. Governing Law:

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

12. It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to any person covered under the policy for any claim hereunder and such claim shall not, within 12 calendar months from the date of such disclaimer have been made subject of the suit in a court of law, then the claim shall for all purpose be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

13. Subrogation :

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Either the Policyholder and/or any Insured Persons shall at their own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company are, or would become entitled upon the Company making reimbursement under this Policy, whether such acts or things shall be or become necessary or required before or after Our payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at their own expense provide us with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and our costs and expenses of affecting a recovery, whereafter, We shall pay any balance remaining to the Insured Persons/Policyholder.

14. Renewal:

This policy may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The Company, however, shall not be bound to give notice that policy is due for renewal or to accept any renewal premium. Unless renewed as herein provided, this policy shall automatically terminate at the expiry of the period for which premium has already been paid.

Cumulative Bonus

Basic Sum Insured under Section 2 of the policy shall be increased by 5% at each renewal in respect of each claim free year of insurance, subject to maximum of 50% of the Sum Insured. In case of any revision in Sum Insured at the time of renewal, the Cumulative Bonus % shall be applied either on revised Sum Insured or the expiring Policy Sum Insured, whichever is less. In case of a claim under Section 2 of the policy in respect of an Insured Person who has earned the cumulative bonus, the increased percentage will be reduce by 10% of the of the Sum Insured at the next renewal. However, the basic Sum Insured will be maintained and will not be reduced. Cumulative Bonus will be lost if the policy is not renewed on the date of expiry unless the delay is condoned up to maximum of 15 days and waived by the Company. Transfer of Cumulative bonus shall not mean continuity of benefits from any expiring Health Insurance Policy.

15. Where proposal forms are not received, information obtained from the policyholder whether orally or otherwise is captured in the policy document. The policyholder 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.

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16. Grievance:

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.

GENERAL EXCLUSIONS

1. Injury or disease directly or indirectly caused by or arising from or attributable to:

   a. War, war-like operations, act of foreign enemy, invasion of Indian territory or any part thereof, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion, military or usurped power, or loot or pillage in connection with the foregoing, seizure, capture, confiscation, arrests, restraints and detainment by order of any governments or any other authority, unless it is proved by the Insured to the satisfaction of the Company that such loss or damage or contingency or cost or expenses of whatsoever nature are not directly or indirectly caused by, resulting from or in connection with any war, war-like operations, act of foreign enemy, invasion of Indian territory or any part thereof, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion, military or usurped power, or loot or pillage in connection with the foregoing, seizure, capture, confiscation, arrests, restraints and detainment by order of any governments or any other authority.

   In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

   b. Ionizing radiation or contamination by radioactivity from any source whatsoever.

   c. Nuclear/Biological/Chemical or any kind of Weapons/Weapons material.

2. Suicide or self-inflicted injury.
3. Abuse of Alcohol or drugs, narcotic substances, tobacco, gutka or use of intoxicating substances or such abuse or addiction etc.
4. Illness or Bodily Injury whilst performing duties as a serving member of a military or a police force.
5. Treatment relating to sterility and venereal disease.

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6. Any sexually transmitted diseases. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex Syndrome (ARCS) and all diseases caused by and/ or related to the HIV.
7. Insured Person committing any breach of law

Treatment for any Injuries sustained whilst or as a result of participating in any criminal act

SECTION I – PERSONAL ACCIDENT

If during the period of insurance an insured person sustains bodily injury which directly and independently is the sole cause of death or permanent total disablement within twelve (12) months of the date of loss, then the company agrees to pay to the insured person's beneficiary / nominee or legal representative of the compensation stated in the schedule.

For all injuries which shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss as stated in the Table Below, the commensurate benefit as shown therein shall be paid to the Insured Person.

The Disablement	*Compensation* Expressed as a Percentage of Total *Sum insured*
1) *Permanent Total Disablement*	100%
2) Permanent Total Loss of two *Limbs*	100%
3) Permanent Total *Loss of Sight* in both eyes	100%
4) Permanent Total *Loss of Sight* of one eye and one *Limb*	100%
5) Permanent Total Loss of one *Limb*	50%
6) Permanent Total *Loss of Sight* of one eye	50%

Permanent Total Disablement means disablement, as the result of a Bodily Injury resulting solely and directly from accident caused by outward, violent and visible means which:

a. Directly And Independently Of All Other Causes Results In Disablement Within Twelve (12) Months Of The Date Of Loss and
b. is confirmed as total, continuous and permanent by a Physician after the twelve (12) consecutive months end, and
c. entirely prevents an Insured Person from engaging in or giving attention to gainful occupation of any and every kind for the remainder of his/her life.

Specific Conditions:

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If applicable and if payment has been made under the Permanent Total Disablement Section, all amounts paid under that Section would be deducted from payment of a claim under this Section of the Policy.

Specific Definitions:

Nominee: Means a person designated by the Insured / Insured Person / Policyholder to receive the proceeds of the insurance policy, upon the death of the Insured.

Beneficiary: Means any person or other legal entity who receives the benefit of the policy in case of death of the Insured during the Policy Period.

Specific Exclusions:

The Company shall not be liable to pay any benefit in respect of any Insured Person:

1. Payment of compensation in respect of injury or disablement directly or indirectly arising out of or contributed to by or traceable to any disability existing on the date of issue of this Policy.
2. for Bodily Injury or Sickness occasioned by Civil War or Foreign War.
3. for Bodily Injury or Sickness caused or provoked intentionally by the Insured Person.
4. for Bodily Injury or Sickness due to willful or deliberate exposure to danger, (except in an attempt to save human life), intentional self-inflicted injury, suicide or attempt thereat, or arising out of non-adherence to medical advice.
5. for Bodily Injury or Sickness sustained or suffered whilst the Insured Person is or as a result of the Insured Person being under the influence of alcohol or drugs or narcotics unless professionally administered by a Physician or unless professionally prescribed by and taken in accordance with the directions of a Physician.
6. for Bodily Injury due to a gradually operating cause.
7. for Bodily Injury sustained whilst or as a result of participating in any sport as a professional player.
8. for Bodily Injury sustained whilst or as a result of participating in any competition involving the utilization of a motorized land, water or air vehicle.
9. for Bodily Injury whilst the Insured Person is traveling by air other than as a fare paying passenger on an aircraft registered to an airline company for the transport of paying passengers on regular and published scheduled routes.
10. for Bodily Injury sustained whilst or as a result of participating in any criminal act.
11. for Bodily Injury or Sickness resulting from pregnancy within twenty-six (26) weeks of the expected date of birth.

12. for Bodily Injury or Sickness caused by or arising from the conditions commonly known as Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) and/or any related illness or condition including derivatives or variations thereof howsoever acquired or caused. The onus shall always be upon the Insured Person to show that Bodily Injury or Sickness was not caused by or did not arise through AIDS or HIV.
13. for Bodily Injury or Sickness caused by or arising from or due to venereal or venereal related disease.
14. for Bodily Injury sustained whilst or as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder.
15. for Bodily Injury sustained whilst on service or on duty with or undergoing training with any military or police force, or militia or paramilitary organization, notwithstanding that the Bodily Injury occurred whilst the Insured Person was on leave or not in uniform.
16. for treatments for nervous or mental problems, whatever their classification, psychiatric or psychotic conditions, depression of any kind, or mental insanity.
17. any pathological fracture.
18. for cures of any kind and all stays in long term care institutions (retirement homes, convalescence centres, centres of detoxification etc.).
19. for 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.
20. for Bodily Injury sustained whilst or as a result of active participation in any hazardous sport such as parachuting, hangliding, parasailing, off-piste skiing or bungee jumping.

SECTION II – HOSPITALISATION INSURANCE

If any Insured Person suffers an Illness or Accident during the Policy Period that requires, that Insured Person's Hospitalisation as an inpatient, then the Company will pay:

1. In-patient Treatment
   a. Room/Boarding Expenses as provided by the hospital/nursing home shall be limited to a maximum of 1% of sum insured or rs. 400 whichever is higher;
   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, any

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medical expenses incurred which is an integral part of the operation, and similar other expenses.

2. Day Care Treatments

The Medical Expenses for a day care procedure or surgery mentioned in the list of Day Care Treatments in this Policy where the procedure or surgery is taken by the Insured Person as an inpatient for less than 24 hours in a Hospital (but not the outpatient department of a Hospital).

1. **Specific Conditions:**

a. **Minimum Period of Hospitalisation:**

A member of Insured family shall be eligible to claim expenses of hospitalisation only if hospitalisation has been for minimum period of twenty four (24) hours. However, this minimum time limit of twenty four (24) hours shall not apply to the list of Day Care Treatments as stated in the Annexure.

If the surgeries mentioned in the Day Care Treatments are for a pre-existing disease then the same is not covered unless they are included specifically by passing a suitable amendment in the policy.

b. **Any One Illness**

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 45 days from date of discharge from the hospital/nursing home where treatment was taken. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

2. **Specific Definitions:**

2.1. **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.

2.2. **Immediate Family Member** means an Insured person's children; children-in-law; siblings; siblings-in-law; parents; parents-in-law; grandparents; grandchildren; legal guardian, ward; adopted children; children from a previous marriage; step-parents; aunts, uncles; nieces, and nephews, who reside in the same country as the Insured person.

2.3 **In-Patient** means a member of Insured family who is admitted to a hospital/nursing home for the sole purpose of receiving treatment for a minimum period of 24 hours.

2.4 **Insured Family** means family comprising the Policyholder and any one or more of the following:

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a. Spouse who permanently resides with the policyholder
b. Dependent children of an Insured person who
   - are financially dependent on the Insured person
   - between the age of 3 months and 18 years in case the Dependent child has completed education. In cases where the Dependent Child is pursuing education from any educational institution the maximum age may be extended upto 25 years.
   - Permanently resides with the policyholder.
   - Maximum of 4 dependent children can be included in the policy.

2.6 **Medical Practitioner** means a person currently legally licensed and registered by the Medical Council of the respective state of India to practice medicine. The term Medical Practitioner includes qualified Physician, Specialist and Surgeon, 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.

2.7 **Pre-Existing Condition** means 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 prior to your first policy with us.

Exclusion: Benefits will not be available for any condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy with us.

3. Specific Exclusions:

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

1. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the Special Conditions.
2. All non medical expenses including personal comfort and convenience items or services such as telephone, television, servant/ maid / barber, or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc, guest services and similar incidental expenses or similar services.
3. Cost of cochlear implant(s).
4. Any treatment/surgery for change of gender or treatment/surgery /complications/illness arising as a consequence thereof.

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5. Experimental and unproven treatment, any Illness or Injury caused by or as a result of or as a consequence of undergoing any experimental or unproven treatment, stem cell transplantation / stem cell surgery (except bone marrow transplant), diagnostic tests and treatment not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury for which Hospitalisation is required.
6. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
7. Vitamins and tonics, treatment of obesity (including morbid obesity), and any other weight control programs, photodynamic therapy, ozone therapy, chelation therapy, services or supplies, general debility, convalescence (convalescent home, convalescent hospital), or treatment received at health spa, hydro clinic, nature care clinics or similar establishments, treatment related to run-down condition and rest cure, hospitalisation for the purpose of Physiotherapy, Occupational therapy.
8. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council.
9. Any kind of Service charges, surcharges, admission fees / Registration charges, charges for documentation etc levied by the hospital.
10. Massages, steam bathing, shirodhara, and the like treatment.
11. Any bills/receipts other than those from institutions where the services were rendered.

3.2 All diseases or injuries which are a pre-existing condition or disease.

3.3 Any disease other than those stated in clause 3.4 below contracted during the first thirty (30) days from the commencement date of the policy. This condition shall not however, apply in case the claimant has been covered under this policy for a continuous preceding twelve (12) month period without any break.

3.4 Expenses incurred on treatment of following diseases within the specified period mentioned in the schedule of the policy from the commencement of the Cover Period, will not be payable:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Endometriosis, Hysterectomy unless malignant, proven on Histopathological examination.
- All types of Hernia, Hydrocele, Varicocele
- Fissures &/or Fistula in anus, haemorrhoids/piles, Pilonidal Sinus
- Arthritis, gout, rheumatism and spinal disorders including Prolapse Intervertebral disc (PIVD)
- Joint replacements unless due to accident
- Sinusitis and related disorders

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- Surgeries of the genito urinary and biliary systems unless malignant, proven on Histopathological examination.
- Dilatation and Curettage
- All types of Skin and internal tumours/ cysts/nodules/ polyps/ulcers of any kind including breast lumps (each of any kind unless malignant, proven on Histopathological examination).
- Dialysis
- Surgery on tonsils, adenoids and mastoid, chronic suppurative otitis media
- Gastric and Duodenal ulcers
- Deviated Nasal Septum (DNS)
- Surgery for Varicose Veins
- Coronary Artery Bypass Graft (CABG)
- Percutaneous Transluminal Coronary Angioplasty (PTCA)
- Heart Valve Replacement
- Organ Transplants
- Chemotherapy
- Polycystic Ovarian Diseases
- Minimally Invasive Coronary Artery Surgery (MICAS)

If these diseases are a pre-existing condition at the time of proposal, they will not be covered even during subsequent period of renewal. if the claimant under the policy is aware of the existence of congenital internal disease before inception of policy, the same will be treated as a pre-existing condition.

3.5 Treatment arising from or traceable to pregnancy and childbirth, miscarriage, abortion and its consequences, tests and treatment relating to infertility and invitro fertilization. However, this exclusion does not apply to ectopic pregnancy proved by diagnostic means and certified to be life threatening by the treating Medical Practitioner.

3.6 Expenses incurred in connection with voluntary medical termination of pregnancy, Birth control procedures and hormone replacement therapy.

3.7 Naturopathy, Ayurvedic and any other form of alternative medical treatment.

3.8 Homeopathy Medical treatment.

3.9 Charges for prosthesis (except for artificial limbs, joint replacement prosthesis), corrective devices, durable medical equipments and items and medical appliances/apparatus/machines, which are not required intra-operatively or not used during Hospitalisation. These shall include Continuous Positive Airway Pressure (CPAP) machines, Bi-level Positive Airway Pressure (BiPAP) machines, Continuous Ambulatory Peritoneal Dialysis (CAPD), nebulizers / atomizers, infusion pump, ambulatory assist devices i.e. walker, canes,

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crutches, belts, collars, caps, splints, slings, braces, stockings, similar items of any kind, diabetic footwear, glucometer, glucostrips, thermometer, and similar related items, and also any medical equipment which is subsequently used at home.

3.10 Home visit charges for Medical Practitioner, Nurses/Attendants, Physiotherapists, Laboratory technicians incurred during Pre-hospitalisation period or Post-hospitalisation period.

3.11 Treatment of mental illness, stress, psychiatric or psychological or psychosomatic disorders. Aesthetic treatment, cosmetic surgery and plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Third Degree Burns.

3.12 Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.

3.13 Expenses incurred at the hospital or nursing home primarily for evaluation / diagnostic purposes / general health check-up.

3.14 Costs of donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery.

3.15 Any travel or transportation expenses including ambulance charges.

3.16 Any treatment related to sleep disorder or sleep apnoea syndrome.

3.17 Any stay in the hospital where no active regular treatment is given by the Medical Practitioner.

3.18 Treatment which is continued before hospitalisation and continued during and after discharge for an ailment / disease / injury not related to the one for which hospitalisation was necessary.

3.19 The following expenses namely Surcharge, service charge, admission charges, administrative charges, telephone charges, linen charges, food expenses which are other than the regular meals provided by the hospital to the patient, charges billed by the Medical Records Department (MRD) charges, stationary and filing charges.

3.20 All dental treatment unless caused due to Accident.

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3.21 Treatment relating to Congenital Conditions and complications resulting thereof.

3.22 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.

3.23 Routine medical, eye and ear examinations, cost of spectacles, all types of refractive eye surgeries, contact lenses, hearing aids, multifocal intraocular lens/implants, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel or any other such purpose.

3.24 Charges incurred at hospital/ nursing home 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 / Nursing Home.

3.25 Treatment by an immediate family member and self-medication or any treatment that is not scientifically recognized.

3.26 Day Care Surgeries not forming a part of any Surgery/Treatment mentioned in the Day Care Treatment List

3.27 Expenses incurred for pre and post hospitalisation medical care.

3.28 Any expenses incurred in Pre-hospitalisation and Post-hospitalisation period for Surgeries / treatment with less than 24 hours hospitalisation.

3.29 Domiciliary treatment

4. Specific Conditions:

4.1 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 Company within fifteen (15) days from the date of hospitalisation.

4.2 All supporting documents relating to the claim must be filed within thirty (30) days from the date of discharge from the hospital/nursing home.

4.3 The member of the Insured family shall obtain and furnish to the Company, 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 Company may require in dealing with the claim.

4.4 Other Insurance: If, at the time when any claim arises under this policy, there is in existence any other insurance whether it be effected by or on behalf of any member of Insured Family in respect of whom the claim may have risen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more than its

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rateable proportion of any loss, liability, compensation, costs or expenses. The benefits under this policy shall be in excess of the benefits available under Cancer Insurance Policy.

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

4.6 A policy shall reimburse only those expenses, which are incurred during the policy period. However, if a claim spreads over two policy periods the total benefit will not exceed the Sum insured of the policy period during which the member of Insured family was admitted to the hospital / nursing home.

4. 7 Cashless Hospitalisation Conditions:

a. The Company/TPA may provide a health card to the Insured under this Policy to avail of cashless hospitalisation facility. The Insured can avail of cashless hospitalisation facility under this Policy at the time of admission into any Hospital which has a tie-up with the TPA/ Company by production of this health card subject to the terms and conditions for the usage of the health card as communicated to the Insured by the TPA/Company.

b. Cashless hospitalisation facility will not be available if treatment is taken in a Hospital where the TPA/Company does not have any tie-up to provide such facility. The TPA/ Company shall have the right to deny cashless hospitalization facility in case accurate and complete information is not forthcoming for the Illness or Bodily Injury for which cashless hospitalization facility is sought. It shall be at the sole discretion of the TPA / Company to provide this cashless hospitalization facility under the above mentioned circumstances.

c. Intimation to the Company/TPA with accurate and complete details regarding Hospitalization before or within 24 hours of admission to the Hospital is compulsory to avail of the cashless hospitalization facility. However no request for cashless hospitalization facility shall be admissible after discharge from hospital.

5 . Claims Procedure:

5.1 When and How To Make A Claim

It is a condition precedent to the Company's liability that upon the discovery or happening of any Illness or Bodily Injury that may give rise to a claim under this Policy, the Insured or his representative (if the Insured is incapacitated or a minor) shall undertake the following:

5.1.1 Claim Notification

The Insured or his representative, as the case may be, shall give immediate notice to the appointed Third Party Administrator (TPA) or the Company (in case no TPA is

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appointed) by calling the toll free number as specified in the health card/ Policy provided to the Insured Person and also in writing at the address of the Company with particulars as below:

- Policy Number;
- Name of the Insured Person availing treatment;
- Policyholder's relation to the Insured;
- Nature of Illness or Bodily Injury;
- Name and address of the attending Medical Practitioner and the Hospital; and Any other relevant information.

The above information needs to be provided to the TPA/Company immediately and prior to availing treatment and in any case within 15 days from date of admission/ date of availing treatment, failing which the TPA / Company has the right to treat the claim as inadmissible or to pay a maximum of 80% of the admissible amount, as they may deem fit.

5.1.2 Prior Authorization

For cashless Hospitalisation, the Insured must contact the Third party Administrator/Company at least 48 hours before a planned Hospitalisation. In an emergency situation the Third Party Administrator/ Company sould be contacted within 24 hours of Hospitalisation.

5.1.3 Claim Processing

The Third Party Administrator appointed by the Company will process the claim on behalf of the Company and make all relevant payments with respect to the claims.

The Policyholder or the Insured is required to deliver at their own costs, to the TPA/Company, within 30 days of the Insured's discharge from Hospital (and for Post-hospitalisation medical charges, if covered, within 10 days from the completion of Post-hospitalisation period or completion of treatment, whichever is earlier), any and all information and documentation in original concerning the claim or the Company's liability for it, including but not limited to:

- Duly completed claim form(s).
- Bills, receipts and discharge summary /card from the Hospital where the treatment was taken by the Insured Person(s).
- Bills from chemists supported by proper prescription.
- Investigation test reports and payment receipts of the centre where the investigations/tests are carried out.
- Bills, receipts and prescriptions of the Medical Practitioner

- Indoor case papers
- Bills, Invoice of implant(s) along with sticker(s), utilised for the treatment.
- Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases.
- Any other document as required by the Company/ TPA.
- First Information Report / Medico Legal Certificate for Road Traffic Accidents and other medico legal cases.

If so required by the TPA/Company, the Insured will have to submit to a medical examination by the Company's or TPA's nominated Medical Practitioner as and when the TPA/Company considers necessary.

In the event of Insured's death, written notice accompanied by a copy of the post mortem report (wherever applicable) should be given to the Company within 14 days regardless of any prior notice been given to the Company. Autopsy Report can be requisitioned at the discretion of the Company wherever found reasonable.

5.2 PAYMENT OF CLAIMS

5.2.1 Any relapse of the Illness or Bodily Injury covered under the Policy within 45 days of the date when the Insured was last treated by the Medical Practitioner shall be deemed to be the part of the same claim.

5.2.2 No indemnity under this SECTION II is available if the period of Hospitalisation is less than 24 hours except in the case of Day Care Treatments.

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