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HDFC ERGO General Insurance Company Limited will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the terms and conditions of this Policy, Your payment of premium, and Your statements in the Proposal, which is incorporated into the Policy and is the basis of it.

SECTION A. DEFINITIONS

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

Standard Definitions

- Def. 1 Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- Def. 2 Any one illness** means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken
- Def. 3 AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
- a. Central or State Government AYUSH Hospital; or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
- Def. 4 AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

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- i. Having qualified registered AYUSH Medical Practitioner (s) in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 5 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 is approved.

Def. 6 Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon

Def. 7 Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- a) Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.
- b) External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body

Def. 8 Cumulative Bonus means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 9 Day care Centre means any institution established for Day Care Treatment of Illness and / or injuries or a medical set -up with 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 criterion as under:-

- I. has qualified nursing staff under its employment;
- II. has qualified medical practitioner/s in charge;
- III. has fully equipped operation theatre of its own where surgical procedures are carried out;
- IV. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 10 Day Care Treatment/ Procedures means those medical treatment, and/or surgical procedure which is

- i) undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and
- ii) which would have otherwise required Hospitalization of more than 24 hours,

Treatment normally taken on an Out-patient basis is not included in the scope of this definition

Def. 11 Deductible means 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

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any benefits are payable by the insurer. A Deductible does not reduce the sum insured.

Def. 12 Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 13 Disclosure of information norm means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 14 Domiciliary Hospitalization 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:

- I. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- II. the patient takes treatment at home on account of non-availability of room in a Hospital

Def. 15 Emergency Care means management for an 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 of the insured person's health.

Def. 16 Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period

Def. 17 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:

- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 18 Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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Def. 19 Illness/Illnesses means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

(a) Acute condition - Acute condition is a 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:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. 5. it recurs or is likely to recur

Def. 20 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.

Def. 21 In-patient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 22 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.

Def. 23 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 24 Maternity Expenses means

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during Hospitalization).
- b. Expenses towards lawful medical termination of pregnancy during the policy Period.

Def. 25 Medical Advice means any consultation or advise from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 26 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

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had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Def. 27 Medically Necessary means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 28 Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured person's and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 29 Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer

Def. 30 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 by a cashless facility.

Def. 31 Non Network means any Hospital, day care centre or other provider that is not part of the Network

Def. 32 Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized mode of communication.

Def. 33 OPD Treatment means 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 daycare or inpatient.

Def. 34 Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer. Pre- Hospitalisation Medical Expenses means the Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

- I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

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Def. 35 Post- Hospitalisation Medical Expenses means the Medical Expenses incurred during the pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that:

- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 36 Pre-existing disease means any condition, ailment, injury or disease:

- a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

Def. 37 for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the 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

Def. 38 Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services ,taking into account the nature of illness/ injury involved.

Def. 39 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the Associated medical expenses.

Def. 40 Renewal means 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

Def. 41 Surgery or Surgical Procedure 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 from suffering and prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner

Def. 42 Unproven/Experimental Treatment is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

Specific Definitions

Def. 1 Adventurous/Hazardous Sports means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

Def. 2 Age or Aged means completed years as at the Policy Commencement Date.

Def. 3 Alternative treatments means forms of treatments other than treatment "Allopathic" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

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- Def. 4 Associated Medical Expenses** means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person
- Def. 5 AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- Def. 6 Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
- Def. 7 Biological attack** or weapons the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death
- Def. 8 Break in policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
- Def. 9 Chemical attack or weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
- Def. 10 Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule.
- Def. 11 Contribution** means 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 rateable proportion of Sum Insured.
- Def. 12 Dependents** means only the family members listed below:
- a) Your legally married spouse as long as she continues to be married to You
 - b) Your children Aged between 91 days and 21 years if they are unmarried, still financially dependent on You and have not established their own independent households;
 - c) Your natural parents or parents that have legally adopted You, and Your parents in law
- Def. 13 Family Floater** means a Policy described as such in the Policy Schedule where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date.
- Def. 14 Insured Person** means the persons named in the Policy Schedule and insured under the Policy.
- Def. 15 Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
- Def. 16 Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium.
- Def. 17 Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), and the Policy Schedule (as the same may be

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amended from time to time).

Def. 18 Policy Period means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule

Def. 19 Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 20 Sum Insured means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Year

Def. 21 We/Our/Us means the HDFC ERGO General Insurance Company Limited

Def. 22 You/Your/Policyholder means the person named in the Policy Schedule who is insured under the Policy or has proposed and concluded this Policy with Us.

SECTION B. BENEFITS**I. Hospitalisation Cover**

Claims made in respect of any of the benefits below will be subject to the Sum Insured and will affect entitlement to a Cumulative bonus.

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's Hospitalisation as an inpatient, then We will pay for the Medical Expenses for the benefits mentioned below, in excess of the Deductible stated in the Schedule.

Our maximum liability for a continuous period of Illness, including relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Schedule of Benefits. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

1. In-patient Treatment

The Medical Expenses for:

- i. Room rent, boarding expenses,
- ii. Nursing,
- iii. Intensive care unit,
- iv. Medical Practitioner(s),
- v. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
- vi. Medicines, drugs and consumables,
- vii. Diagnostic procedures,
- viii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

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Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient Treatment' cover if undertaken in an AYUSH Hospital. However, any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.

2. Pre-Hospitalisation

The Pre-Hospitalization Medical Expenses incurred in the 60 days immediately before the Insured Person was Hospitalized, provided that:

Such Medical Expenses were in fact incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

3. Post-hospitalisation

The Post-hospitalization Medical Expenses incurred in the 90 days immediately after the Insured Person was discharged post Hospitalisation provided that:

Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalisation was required, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

4. Day Care Procedures

The Medical Expenses for a day care procedure mentioned in the list of Day Care Procedures 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 or standalone day care centre but not the outpatient department of a Hospital or standalone day care centre.

5. Domiciliary Treatment

The Medical Expenses incurred by an Insured Person for medical treatment taken at his home which would otherwise have required Hospitalisation because, on the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or a Hospital bed was unavailable, and provided that:

The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period, and

6. Organ Donor

The Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

The organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended) and

The organ donated is for the use of the Insured Person, and

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We will not pay the donor's pre and post-Medical Expenses or any other medical treatment for the donor consequent on the harvesting, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

7. Emergency Ambulance

We will reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate Emergency facilities for the provision of health services following an Emergency, provided that:

Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, provided that transportation has been prescribed by a Medical Practitioner and is medically necessary.

II. Renewal Benefit**1. Cumulative Bonus**

- a. On Renewal of this Policy with the Company without a break, a sum equal to 5% of the Base Sum Insured of the expiring Policy shall be provided as CB irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions. In case where the Policy is on individual basis as specified in the Policy Schedule, the CB shall be added and available individually to the Insured Person..
- b. In case where the Policy is on floater basis, the CB shall be added and available to the family on floater basis.
- c. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- d. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.
- e. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Sum Insured into two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 21 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
- f. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
- g. If the Sum Insured under the Policy has been increased at the time of Renewal, the CB shall

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be calculated on the Sum Insured of the last completed Policy Year.

- h.** If the Policy Period is of two/three years, any CB that has accrued for the first/second Policy Year shall be credited post completion of each Policy Year.
- i.** New Insured Person added to the Policy during subsequent Renewals will be eligible for CB as per their Renewal terms.
- j.** CB shall be available only if the Cover is specified to be applicable in the Policy Schedule.
- k.** Cumulative bonus can be accrued maximum upto 50%

SECTION C. WAITING PERIODS AND EXCLUSIONS

1. Standard Exclusions and Waiting Period

Waiting Periods

- a) Claims under the Policy are covered subject to waiting Period as specified below:

Pre-existing Diseases - Code - Excl01

- i.** Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36months of continuous coverage after the date of inception of the first policy with insurer.
- ii.** In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.
- iii.** If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- iv.** Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

Specified Disease/Procedure waiting period: Code - Excl02

- i.** Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.
- ii.** In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii.** If any of the specified disease/procedure falls under the waiting period specified for Pre-existing diseases, then the longer of the two waiting periods shall apply.
- iv.** The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- v.** If the Insured Person is continuously covered without any break as defined under the

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applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

- i)** Illnesses: arthritis if non infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/fistula in anus, hemorrhoids, pilonidal sinus, gastric and duodenal ulcers; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); osteoarthritis and osteoporosis; polycystic ovarian diseases; sinusitis, Rhinitis, Tonsillitis and skin tumors unless malignant.
- ii)** Treatments: benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy; joint replacement; myomectomy for fibroids; surgery of gallbladder and bile duct unless necessitated by malignancy; surgery of genito urinary system unless necessitated by malignancy; surgery of benign prostatic hypertrophy; surgery of hernia; surgery of hydrocele; surgery for prolapsed inter vertebral disk; surgery of varicose veins and varicose ulcers; surgery on tonsils and sinuses; surgery for nasal septum deviation.

30 day Waiting Period: Code- Excl03

- i.** Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
- ii.** This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
- iii.** The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Permanent Exclusions

We will not make any payment for any claim in respect of any Insured Person , caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this Policy:

- i)** Investigation & Evaluation: Code Excl04
 - a)** Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
 - b)** Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
- ii)** Rest Cure, rehabilitation and respite care–Code – Excl05: Expenses related to any admission

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primarily for enforced bed rest and not for receiving treatment. This also includes:

- a)** Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - b)** Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
 - iii)** Obesity/Weight control: Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 - a)** Surgery to be conducted is upon the advice of the doctor
 - b)** The surgery/procedure conducted should be supported by clinical protocols
 - c)** The member has to be 18 years of age or older and
 - d)** Body Mass Index (BMI)
 - a)** Greater than or equal to 40 or,
 - b)** Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - 1.** Obesity related cardiomyopathy
 - 2.** coronary heart disease
 - 3.** severe sleep apnoea
 - 4.** uncontrolled type2 diabetes
 - iv)** Change-of-Gender treatments - Code – Excl07: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
 - v)** Cosmetic or plastic surgery: Code – Excl08: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
 - vi)** Hazardous or Adventure Sports: Code – Excl09– Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.
 - vii)** Breach of Law: Code – Excl10 - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
 - viii)** Excluded Providers- Code – Excl11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization

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are payable but not the complete claim.

- ix)** Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12
- x)** Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code – Excl13
- xi)** Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. Code – Excl14
- xii)** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries. Code – Excl15
- xiii)** Unproven Treatments– Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. Code – Excl16
- xiv)** Sterility and Infertility – Code – Excl17 - Expenses related to sterility and infertility. This includes:
 - a)** Any type of contraception, sterilization
 - b)** Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c)** Gestational Surrogacy
 - d)** Reversal of sterilization
- xv)** Maternity: Code – Excl18
 - a)** Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b)** Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.

2. Specific Exclusions**i. Deductible**

We are not liable for any payment unless the Medical Expenses exceed the Deductible (as opted on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy). Deductible shall be applicable per Policy Year basis.

- ii.** War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical or Biological attack or weapons, radiation of any kind.

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- iii.** Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
- iv.** Any Insured Person's participation or involvement in naval, military or air force operation.
- v.** Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
- vi.** Congenital external diseases, defects or anomalies,
- vii.** Stem cell harvesting
- viii.** Investigative treatments for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
- ix.** Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
- x.** Any Convalescence, ,sanatorium treatment, private duty nursing or long-term nursing care.
- xi.** Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
- xii.** Vaccination including inoculation and immunisations (Except post Animal bite treatment),
- xiii.** Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.
- xiv.** Treatment taken on Outpatient basis
- xv.** The provision or fitting of hearing aids, spectacles or contact lenses.
- xvi.** Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, Optometric therapy.
- xvii.** Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.
- xviii.** Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively). prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com
- xix.** Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

SECTION D. GENERAL CONDITIONS**Standard General Conditions****1. Condition Precedent to admission of Liability**

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

2. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

3. Claim Settlement (Provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the bank rate.
- iii. Our liability to make payment under this policy will only begin when the Deductible as mentioned in Schedule is exceeded. We will pay to the Insured Person, Medical Expenses over and above Deductible but not exceeding the Sum Insured for the Policy Period.
- iv. Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an Emergency.
- v. This Policy only covers medical treatment taken within India, and payments under this Policy shall only be made in Indian Rupees within India.
- vi. In case of any other concurrent health insurance policy, the amount paid by the other insurer for emergency ambulance would be deducted from the amount claimed under Section B.I-7 Emergency Ambulance of Health Suraksha – Top up Pro Policy, subject to the actual or Rs 2000 whichever is less.

4. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5. Fraud

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If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

6. Multiple Policies

- i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
- ii. Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this Policy.
- iii. If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.
- iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

7. Moratorium Period

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

8. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

9. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

10. Renewal of Policy

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

- a) Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.
- b) The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
- c) No loading shall apply on renewals based on individual claims experience
- d) The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.
- e) Renewal premium due can be paid prior to the due date as per norms set out by the Company.

11. Cancellation

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The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

The Company may cancel the Policy at any time on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud or non-disclosure or misrepresentation.

Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

12. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of 30days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

13. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

14. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

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- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

15. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

16. Grievance Redressal Procedure

In case of any grievance the insured person may contact the company through:

First Point of Contact	Call us at 022 6158 2020 / 022 6234 6234 / www.hdfcergo.com
Level 1	<p>For lack of a response or if the response provided does not meet your expectation, you can:</p> <ol style="list-style-type: none"> Write to The Complaints & Grievance Cell (C&G Cell) HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra You can also write an email to grievance@hdfcergo.com Call on 18002677444 (operational Monday - Saturday 9AM to 6PM)
Level 2	<p>If you're not satisfied with the resolution or if no response was received within 15 days, you can:</p> <ol style="list-style-type: none"> Write to the Chief Grievance Officer HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra You can also write an email to cgo@hdfcergo.com
Level 3	<p>In case grievance is not resolved at the above escalation levels, you can also lodge an online complaint through the website of Council for Insurance Ombudsmen (CIO) www.cioins.co.in</p>

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Dedicated Helpline For	Email ID	Contact Number
Senior Citizen	seniorcitizen@hdfcergo.com	022 6158 2026
Women	-	022 6158 2055

You may also refer the Grievance Redressal Escalation matrix on our website

<https://www.hdfcergo.com/customer-voice/grievances>

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management System -

<https://bimabharosa.irdai.gov.in>

Specific General Conditions**1. Insured Person**

Only those persons named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of max.150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us.

2. Loadings

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of max. 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

We will not apply any additional loading on Your policy premium at Renewal based on claim experience in Your Policy.

Please note that We will issue Policy only after getting Your consent.

3. Notification of Claim

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	Treatment, Consultation or Procedure:	We or Our TPA must be informed:
i)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalization:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalization in an Emergency:	Within 24 hours of the Insured Person's admission to Hospital.
iii)	For all benefits which are contingent on Our prior acceptance of a claim under Section B.I-1:	Within 15 days of the Insured Person's discharge post hospitalization.
iv)	If any treatment, consultation or procedure for which a claim may be made is required in an Emergency:	Within 15 days of completion of such treatment, consultation or procedure.
v)	In all other cases:	Of any event or occurrence that may give rise to a claim under this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorize such treatment, consultation or procedure.

Note: In the case of a covered Hospitalization, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with a copy of intimation made to the other insurer /Reimbursement Provider immediately but not later than 15 days on knowing that the Deductible is likely to be exceeded.

4. Cashless service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
1)	If any planned treatment, consultation or procedure for which a	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network	At least 48 hours before the planned treatment or

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	claim may be made		Hospital.	Hospitalization
2)	If any treatment, consultation or procedure for which a claim may be made is to be taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalization

5. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. Such documentation will include but is not limited to the following:

- i. Our claim form, duly completed and signed for on behalf of the Insured Person.
- ii. Original Bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property. All hospitalisation expenses incurred in the Hospital must comprise within the Bill from Hospital. Any expenses incurred during Hospitalisation but not part of final bill will not be admissible.
- iii. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
- iv. A precise diagnosis of the treatment for which a claim is made.
- v. A detailed list of the individual medical services and treatments provided and a unit price for each.
- vi. Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor's invoice.

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.

The Insured Person additionally hereby consents to:

- i) The disclosure to Us of documentation, medical records and information that may be held by medical professionals and other insurers.
- ii) Being examined by any Medical Practitioner We authorise for this purpose when and so often as We may reasonably require at Our cost.

6. Alterations to the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or

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varied by anyone (including an insurance agent or broker) except Us, and any change We make will be evidenced by a written endorsement signed and stamped by Us.

7. Non-Disclosure or Misrepresentation

- i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:
 - a. cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us at Our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule and
 - b. the claim under such Policy if any, shall be prejudiced.
- ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;
 - a) Permanently exclude the disease/condition and continue with the Policy
 - b) Incorporate additional waiting period of not exceeding 3years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
 - c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

The above options will not prejudice the rights of the Company to invoke cancellation under clause (i) above.

8. Grace Period

- i. A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.
- ii. Policies for which Premium is received after the Grace Period shall be considered as a fresh policy.
- iii. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

9. Change of Policyholder

The change of Policyholder (except clause XXII) is permitted only at the time of renewal. If You do not renew the Policy, the other Insured Persons may apply to renew the Policy. However, in case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court subject to condition q) above.

10. Notices

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Any notice, direction or instruction under this Policy shall be in writing and if it is to:

- i) Any Insured Person, then it shall be sent to You at Your address specified in the Schedule and You shall act for all Insured Persons for these purposes.
- ii) Us, it shall be delivered to Our address specified in the Schedule. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

11. Dispute Resolution Clause

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.

SECTION E. OTHER TERMS & CONDITIONS**Contact Us**

	Within India	Outside India
Claim Intimation:	Contact No :022 6234 6234 / 0120 6234 6234 Phone (UAN) :1860 2000 700 (Local charges applicable) Fax (UAN) : 1860 2000 600 (Local charges applicable) Email:healthclaims@hdfcergo.com	Global contact No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email travelclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, AndheriKurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

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Ombudsman Details

The contact details of the Insurance Ombudsman offices are as below-

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

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Office Details	Jurisdiction of Office (Union Territory, District)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba,

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Health Suraksha - Top Up Pro

Office Details	Jurisdiction of Office (Union Territory, District)
Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrya Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai , M/East, M/West, N, S and T."

Policy Wording

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Annexure I - List of Non-Medical Expenses

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY

Policy Wording

Health Suraksha - Top Up Pro

SCHEDULE OF BENEFITS

Health Suraksha – Top up Pro- Individual

Benefits	Sum Insured
Sum Insured (Rs. in Lac) per Insured Person per Policy Year	2.00; 3.00; 4.00; 5.00; 7.50; 10.00
Deductible (Rs. In Lacs) (As mentioned in Policy Schedule)	1.00; 2.00; 3.00; 4.00; 5.00
1 a) In-patient Treatment	Covered; Hospitalization for minimum 24 hours required.
1 b) Pre-hospitalization	Covered, maximum up to 60 days
1 c) Post-hospitalization	Covered, maximum up to 90 days
1 d) Day Care Procedures	Covered
1 e) Domiciliary Treatment	Covered
1 f) Organ Donor	Covered
1 g) Emergency Ambulance	Up to Rs. 2000 per Hospitalization.

Health Suraksha – Top up Pro- Family Floater

Benefits	Sum Insured
Sum Insured (Rs. in Lac) per Policy per Policy Year	2.00; 3.00; 4.00; 5.00; 7.50; 10.00
Deductible (Rs. In Lacs) (As mentioned in Policy Schedule)	1.00; 2.00; 3.00; 4.00; 5.00
1 a) In-patient Treatment	Covered; Hospitalization for minimum 24 hours required.
1 b) Pre-hospitalization	Covered, maximum up to 60 days
1 c) Post-hospitalization	Covered, maximum up to 90 days
1 d) Day Care Procedures	Covered
1 e) Domiciliary Treatment	Covered
1 f) Organ Donor	Covered
1 g) Emergency Ambulance	Up to Rs. 2000 per Hospitalization.