

**Preamble**

HDFC ERGO General Insurance 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. INTERPRETATIONS & 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:

1. Standard Definition

Def. 1. Accident or Accidental means a sudden, unforeseen and unexpected event caused by external, violent and visible means (but does not include any Illness) which results in physical bodily injury.

Def. 2. 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:

- 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. 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. **Congenital Anomaly** means a condition 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. 5. **Critical Illness** means Cancer, Coronary Artery (Bypass) Surgery, First Heart Attack (Myocardial Infarction), Kidney Failure (end stage renal disease), Major Organ Transplantation, Multiple Sclerosis, Paralysis and Stroke all as defined below only:

i) Cancer of specified severity:

- a. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- b. The following are excluded:
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
 - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
 - vi. Chronic lymphocytic leukaemia less than RAI stage 3
 - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
 - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ii) Open Chest CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.



II. The following are excluded:

(a) Angioplasty and/or any other intra-arterial procedures

iii) Myocardial Infarction (First Heart Attack of Specified Severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- ii. New characteristic electrocardiogram changes
- iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

- i. Other acute Coronary Syndromes
- ii. Any type of angina pectoris
- iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

iv) Kidney Failure requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

v) Major Organ/ Bone Marrow Transplant

I. The actual undergoing of a transplant of:

- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted

vi) Multiple Sclerosis with Persisting Symptoms:

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and



- ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

vii) Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

viii) Stroke resulting in Permanent Symptoms

- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
- II. The following are excluded:
 - i. Transient ischemic attacks (TIA)
 - ii. Traumatic injury of the brain
 - iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

Def. 6. 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. 7. 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 (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def. 8. 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,

Policy Wording

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- 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. 9. 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.

Def. 10. 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. 11. 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. it recurs or is likely to recur

Def. 12. Inpatient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

Def. 13. Medical Expenses means those Reasonable and Medically Necessary expenses that an Insured Person has necessarily and actually incurred for medical treatment on the advice of a Medical Practitioner due to Illness or Accident and leading to consequent hospitalisation during the Policy Period.

Def. 14. 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. 15. 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. 16. Network Provider means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

Def. 17. Non Network means any Hospital, Day Care Centre or other provider that is not part of the Network

Def. 18. OPD Treatment: OPD treatment means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 19. 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.

Def. 20. Pre-existing Condition means any condition, ailment, injury or disease:

- 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
- 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 policy.

Def. 21. Pre-hospitalization Medical Expenses means 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 Hospitalization was required, and
- ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 22. Post-hospitalization Medical Expenses means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:

- i. Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and
- ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance company.

Def. 23. 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. 24. 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. 25. 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.

2. Specific Definitions

Def. 1. Dependents means only the family members listed below:

- i) Your legally married spouse as long as he/she continues to be married to You;
- ii) Your children Aged between 91 days and 21 years if they are unmarried, still financially dependant on You and have not established their own independent households;
- iii) Your natural parents or parents that have legally adopted You, provided that:
 - a) The parent was below 65 years at his initial participation in the Maxima Insurance Policy, and
 - b) Parents shall not include Your spouse's parents.

Def. 2. 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. 3. Age or Aged means completed years as at the Commencement Date.

Def. 4. AYUSH Treatment refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 5. Bank rate shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 6. Break in policy means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Def. 7. Commencement Date means the commencement date of this Policy as specified in the Schedule.

Def. 8. Entitlement Certificate means the certificate We issue which will operate only as detailed in the introduction to the Part A, Section B benefits.

Def. 9. Family Floater means a Policy whereunder You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 10. Insured Person means You and Your Dependents named in the Schedule.

Def. 11. Material facts for the purpose of this policy shall mean 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. 12. Non-instalment Premium Payment refers to payment of premium for the entire policy period made in advance as a single premium.

Def. 13. Policy means Your statements in the proposal form, this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def. 14. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 15. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 16. Shared Accommodation means a Hospital room with two or more patient beds.

Def. 17. Sum Insured means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all Insured Persons during the Policy Period.

Def. 18. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 19. We/Our/Us means the HDFC ERGO General Insurance Limited

Def. 20. You/Your/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

SECTION B. BENEFITS

Part A – Outpatient Module

Claims made in respect of any of the benefits in this Part A will not be subject to the Sum Insured and will affect the entitlement to a Carry Forward Bonus.

However, our maximum liability for each benefit in Part A.1. shall be limited to the amount specified in the Schedule of Benefits against such benefit. An Insured Person shall only be eligible to take the treatment, consultation or procedure under Part A.1. benefit if all of the following requirements are satisfied:

- a) We have issued an Entitlement Certificate to the Insured Person for the specific treatment, consultation or procedure; and
- b) The Entitlement Certificate is used for the specific treatment, consultation or procedure specified in it; and
- c) Any conditions or limitations specified in the Entitlement Certificate are strictly adhered to; and
- d) The Entitlement Certificate is used (and will only be effective) at only a Network service provider; and
- e) The Insured Person gives the Entitlement Certificate to the Network service provider before receiving or undergoing the treatment, consultation or procedure specified in it.
- f) The treatment, consultation or procedure specified in the Entitlement Certificate is taken or undergone by the Insured Person during the Policy Period.



- g)** The payment of premium in full and in time.
- h)** If an Entitlement Certificate has been used and results in treatment to which Part B responds, then it is agreed and understood that We would be refunding the Entitlement Certificate used for pre-hospitalisation by issuing fresh Entitlement Certificate.

1. Outpatient Benefits

An Entitlement Certificate may be obtained by the Insured Person for his own use for one of the specified treatments, consultations or procedures under a benefit mentioned in a) – f) below:

a) Outpatient Consultations

Outpatient consultation by a general Medical Practitioner or a specialist Medical Practitioner as further specified in the Entitlement Certificate in a Network Hospital.

- i.** The non-network Outpatient consultations will be covered on reimbursement basis subject to the number of consultations and the amount specified in the Schedule of Benefits.

b) Diagnostic Tests

Outpatient diagnostic tests taken by the Insured Person from a diagnostic centre (not necessarily to be prescribed by Network Medical Practitioner).

c) Pharmacy

Medicines purchased by the Insured Person from a pharmacy, provided that such medicines have been prescribed in writing by a Medical Practitioner (not necessarily to be Network Medical Practitioner).

d) Outpatient Dental Treatment

Any necessary dental treatment taken by an Insured Person from dentist,

- i.** provided that We will not pay for any dental treatment that comprises cosmetic treatment and
- ii.** the benefit amount is restricted to Rs. 1,000 per Policy Year
- iii.** If this cover is in force, exclusion xxi under Specific General exclusions shall be superseded to the extent of coverage provided under this benefit

e) Spectacles, Contact lenses

Either one pair of spectacles or contact lenses, as specified in the Entitlement Certificate provided that these have been prescribed for the Insured Person by a Eye specialist Medical Practitioner.

f) Annual Health Check-Up within specified Network

A health check-up as specified in the Schedule of Benefits for the Insured Person within Network.

This benefit is not available to the Insured Persons below 18 years of age and above the age of 45 years in the first Policy Year with Us

**2. Carry Forward Bonus**

- a)** If the Policy is renewed with Us without any break and there are any available Entitlement Certificates are not used by the Insured Person in a Policy Year, then We will carry forward 50% of these Entitlement Certificates to the next Policy Year.
- b)** It is expressly agreed and understood that:
 - (i) A carry forward will only apply in respect of any particular Entitlement Certificate for one Policy Year; and
 - (ii) There shall be no carry forward of any Entitlement Certificate for the benefit under Part A.1.f)
 - (iii) There will be no Carry Forward Bonus unless the originals of all unused Entitlement Certificates are returned to us before renewal (grace period of 15 days from the due date of renewal).
 - (iv) For the purpose of computing carry forward of any Entitlement Certificate; in the event of unused Entitlement Certificates received are in odd number, We will round them off to next increased number.
- c)** To obtain carry forward Entitlement Certificates, You have to send us all unused Entitlement Certificates before renewal. After verifying the Entitlement Certificates and checking the admissibility of Carry Forward Bonus as mentioned above, fresh Entitlement Certificates will be issued within 30 days of the receipt of the unused Entitlement Certificates provided that the policy is renewed with Us without a break.

Part B – Inpatient Module**1. Inpatient Benefits**

Claims made in respect of any of the benefits below will be subject to the Sum Insured and will affect the 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:

a) In-patient Treatment

The Medical Expenses for:

1. Room rent, boarding expenses,
2. Nursing,
3. Intensive care unit,
4. Medical Practitioner(s),
5. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
6. Medicines, drugs and consumables,
7. Diagnostic procedures,



8. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

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. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.

b) Pre-Hospitalisation Medical Expenses

The Medical Expenses incurred in the 30 days immediately before the Insured Person was Hospitalised, provided that:

1. Such Medical Expenses were in fact incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
2. We have accepted an inpatient Hospitalisation claim under Part B.1.a)
3. We will pay the Medical Expenses incurred within the 60 days prior to the date of Hospitalisation, if we are provided with the following at least 5 days before the Hospitalisation:
 4. medical documents with all details about the Illness; and
 5. the date and the place of the proposed Hospitalisation.

c) Post-hospitalisation Medical Expenses

The Medical Expenses incurred in the 60 days immediately after the Insured Person was discharged post Hospitalisation provided that:

1. Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalisation was required, and
2. We have accepted an inpatient Hospitalisation claim under Part B.1.a)
3. We will pay the Medical Expenses in the 90 days immediately after the Insured Person was discharged if We were provided with the following at least 5 days before the Hospitalisation:
 - (1) medical documents with all details about the Illness; and
 - (2) the date and the place of the proposed Hospitalisation.

d) Day Care Procedures

The Medical Expenses for a day care procedure or surgery where the procedure or surgery is Undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and which would have otherwise required Hospitalization of more than 24 hours. Treatment normally taken on an Out-patient basis is not included in the scope of this definition

e) 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 3days, in which case We will pay the reasonable cost of any necessary medical treatment for the entire period, and

f) Daily Cash for choosing Shared Accommodation

Note: Claims made in respect of this benefit will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

A per day cash amount will be payable if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours, provided that:

1. Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and
2. The days of admission and discharge shall not be counted, and
3. This benefit shall not apply to time spent by the Insured Person in an intensive care unit, and
4. We have accepted an inpatient Hospitalisation claim under Part B.1.a)

g) Organ Donor

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

- i) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994and the organ donated is for the use of the Insured Person, and
- ii) We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment for the donor consequent on the harvesting, and
- iii) We have accepted an inpatient Hospitalisation claim under Part B.1.a)

h) 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 (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention), provided that:

- i. Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits per Hospitalisation, and
- ii. We have accepted an inpatient Hospitalisation claim under Part B.1.a)
- iii. 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

i) Daily Cash for Accompanying an Insured Child

Note: Claims made in respect of this benefit will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

If the Insured Person Hospitalised is a child Aged 12 years or less, We will pay a daily cash amount for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours, provided that:

1. Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and
2. The days of admission and discharge shall not be counted, and
3. We have accepted an inpatient Hospitalisation claim under Part B.1.a)

j) Maternity Expenses

Note: Claims made in respect of this benefit will not be subject to the Sum Insured and will not affect the entitlement to a cumulative bonus.

We will pay the Medical Expenses for a delivery (including caesarean section) while Hospitalised or the lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person, provided that:

1. Our maximum liability per delivery or termination shall be limited to the amount specified in the Schedule of Benefits, and
2. We will pay the Medical Expenses of pre-natal and post-natal expenses per delivery or termination upto the amount stated in the Schedule of Benefits, and
3. We will cover the Medical Expenses incurred for the medically necessary treatment of the infant baby upto the amount stated in the Schedule of Benefit sun less the infant baby is covered under Part B.1.k), and
4. This benefit is not available for Dependents other than Your spouse under a Family Floater, and
5. Pre- and post-hospitalisation expenses under Part B.1.b) and Part B.1.c) are not covered under this benefit, and
6. The Insured Person must have been an Insured Person under Our Policy for the period of time specified in the Schedule of Benefits, and
7. We will not cover ectopic pregnancy under this benefit [although it shall be covered under Part B.1.a)].
8. If this cover is in force, exclusion xv under Standard General exclusions shall be superseded to the extent of coverage provided under this benefit

**k) Newborn baby**

Note: This benefit is optional and effective only if noted as such in the Schedule of Benefits. The sum insured of this benefit is above the Maternity Sum Insured limit; will be equivalent to Individual Sum Insured [Rs. 300,000] under 1 Adult plan and Floater Sum Insured [Rs. 300,000] under 2 Adults & upto 2 Children plan.

We will cover the Medical Expenses of any medically necessary treatment described under Part B.1.a) while the Insured Person is Hospitalised during the Policy Period as an inpatient for a Newborn Baby provided that:

1. We have accepted a claim under Part B.1.j), and
2. You have submitted a proposal for the insurance of the newborn baby within 30 working days after the birth, and We have in Our sole and absolute discretion accepted the same and received the premium sought.

Newborn Baby means those babies born to You and Your spouse during the Policy Period Aged between 1 day and 90 days.

2. Cumulative Bonus

On Renewal of this Policy with the Company without a break, a sum equal to 10% of the Base Sum Insured of the expiring Policy shall be provided as Cumulative Bonus irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions:

- a. The maximum Cumulative Bonus will not exceed 50% of the Basic Sum Insured in any Policy Year.
- b. In Family Floater policy, the Cumulative Bonus shall be available on Family Floater basis at policy level
- c. In Family Floater policy, the accrued Cumulative Bonus is available to all Insured Persons under the Policy.
- d. The applicable Cumulative Bonus shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy
- e. If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the Cumulative Bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the Cumulative Bonus to be carried forward for credit in the Policy would be the lowest accrued Cumulative Bonus amongst all the Insured Persons from the expiring Policy.
- f. Portability/migration benefit will be offered to the extent of sum of previous sum insured and accrued Cumulative Bonus, portability/migration benefit shall not apply to any other additional increased Sum Insured.
- g. In policies with a 2/3 year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.

3. Optional Benefit - Critical Illness



Claims made in respect of any of the benefits below will not be subject to the Sum Insured and will not affect entitlement to a cumulative bonus.

If the Schedule shows that the Critical Illness benefit is effective, then We will pay the Critical Illness Sum Insured as a lump sum in addition to Our payment under Part B.1.a), provided that:

(1) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and

(2) The Insured Person survives for at least 30 days following such diagnosis.

We will not make any payment if:

i) The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under a MaximaInsurancePolicy.

ii) The Insured Person has already made a claim for the same Critical Illness.

iii) A claim for this benefit has already been made 3 times under thisPolicy or any other policy issued by Us.

SECTION C. EXCLUSIONS [APPLICABLE TO PART B ONLY]

1. Standard Waiting Periods

All Illnesses, treatments shall be covered subject to the waiting periods specified below:

i. 30-day waiting period: Code - Excl03

a) 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.

b) This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified Disease/Procedure waiting period: Code- Excl02

a) 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.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) 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.

d) The waiting period for listed conditions shall apply even if contracted after the policy or



declared and accepted without a specific exclusion.

- e)** If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures:-

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 and Rhinitis,Tonsilitis 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; nasal septum deviation.

iii. Pre-Existing Diseases: Code - Excl01

- a)** Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- b)** In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c)** 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.
- d)** Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

2. Standard General 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 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 comorbidities 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 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: Code11: 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 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) Refractive Error: Code - Excl15: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

xiii) Unproven Treatments: Code – Excl16: 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.

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.

3.**Specific General exclusions**

- i.** War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection,military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.
- ii.** Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.



- iii.** Any Insured Person's participation or involvement in naval, military or air force operation.
- iv.** Investigative treatment for Sleep-apnoea, general debility or exhaustion ("run-down condition").
- v.** Congenital external diseases, defects or anomalies,
- vi.** Stem cell harvesting
- vii.** Investigative treatment 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).
- viii.** Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
- ix.** Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
- x.** 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.
- xi.** Vaccination including inoculation and immunisations (Except post bite treatment),
- xii.** 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 etc. Full list of Non-Medical expenses attached and is also available at www.hdfcergohealth.com.
- xiii.** Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family, or stays with him,
- 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 method. 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, wheel chairs 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.
- xx.** Any non allopathic treatment except to the extent of coverage provided for under 'In-patient treatment' cover under Part B – In patient module.



- xxi.** Dental treatment and surgery of any kind, unless requiring Hospitalisation.
- xxii.** Any exclusion mentioned in the Schedule or the breach of any specific condition mentioned in the Schedule

SECTION D. GENERAL CONDITIONS

1. Standard General Conditions

a. 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.

b. Claim settlement (Provision for penal interest)

- The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
- 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.

c. 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.

d. Fraud

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 have 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.

i) Entitlement Certificate:

An Entitlement Certificate issued under Part A shall be used solely by the Insured Person named therein. The Insured Person shall not sell, exchange, trade, barter or transfer or allow any person to use his Entitlement Certificate. Any contravention of this condition shall be in addition to any remedies available to Us and shall also be deemed to constitute a failure to satisfy the requirements set out in Part A.

We will replace a lost Entitlement Certificate only when We are satisfied that it is lost. However, We reserve the right to make such investigations into and call for such evidence of the loss of the Entitlement Certificate at Your expense as We consider necessary before issuing a duplicate Entitlement Certificate. Any contravention of this condition shall be in addition to any remedies available to Us and shall also be deemed to constitute a failure to satisfy the requirements set out in Part A.

If the Policy is terminated for any reason, You shall immediately return all Entitlement Certificates issued to all Insured Persons. Any unreturned Entitlement Certificates shall cease to be valid on the date of termination. You shall indemnify and keep Us indemnified and hold Us harmless from and against any claims, costs, expenses, awards or judgments arising out of or in relation to such Entitlement Certificates. This Policy is deemed to incorporate General Condition j) from any previous policy issued by Us.

e. 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.

f. 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.

g. Moratorium Period

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 limits.

h. 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.

i. Cancellation

- i.** 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.
- ii.** 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.
- iii.** 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
- iv.** 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
- v.** 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.

j. 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.
- 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.

k. 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.

l. 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.

m. 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.

n. 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 30 days 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;

o. 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:

- i. 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.
- ii. 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.
- iii. No loading shall apply on renewals based on individual claims experience
- iv. 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.
- v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

p. 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> <ul style="list-style-type: none">1. 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, Maharashtra2. You can also write an email to grievance@hdfcergo.com3. Call on 18002677444 (operational Monday - Saturday 9AM to 6PM)
Level 2	If you're not satisfied with the resolution or if no response was received within 15 days, you can: <ul style="list-style-type: none">1. 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
	2. You can also write an email to cgo@hdfcergo.com
Level 3	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

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>

1. Specific General Conditions

a. Notices

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

- (3) 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.
- (4) 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.

b. 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.

c. 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.
 - i. 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 3 years 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.

d. Alterations to the Policy

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

e. 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 over 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.

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

f. Notification of Claim

	Treatment, Consultation or Procedure:	We or Our TPA must be informed:
i)	If any treatment under Part B for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii)	If any treatment under Part B for which a claim may be made is to be taken and that treatment requires Hospitalisation 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 Part B.1.a):	Within 7 days of the Insured Person's discharge post-Hospitalisation.
iv)	If any treatment, consultation or procedure under Part B for which a claim may be made is required in an emergency:	Within 7 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 Part B of this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorise such treatment, consultation or procedure.

Please note that:

- i) If any time period is specifically mentioned in Part B, then this shall supersede the time periods mentioned in 1)-5) above.
- ii) Emergency means a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention.

g. 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:
2)	If any planned treatment, consultation or procedure for which a claim may be made under Part B:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation
3)	If any treatment, consultation or procedure for which a claim may be made under Part B 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 Hospitalisation

Please note that emergency means a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention.

h. Supporting Documentation & Examination

i. The Insured Person shall provide Us with any documentation and information We or Our TPA may request to establish the circumstances of the claim under Part B, 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:

1. Our claim form, duly completed and signed for on behalf of the Insured Person.
2. 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.
3. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
4. A precise diagnosis of the treatment for which a claim is made.
5. A detailed list of the individual medical services and treatments provided and a unit price for each.
6. 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 Medical Practitioner's invoice if fees have been paid to that Medical Practitioner and are being claimed under the Policy.

ii. The Insured Person additionally hereby consents to:



- 1)** The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.
- 2)** Being examined by any doctor We authorise for this purpose when and so often as We may reasonably require and at Our cost.

i. Claims Payment

- i.** We shall be under no obligation to make any payment under Part B unless We have received all premium payments in full and in time and all payments have been realised and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim under Part B, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy. We shall be under no obligation to provide any benefit through an Entitlement Certificate under Section B Part A unless We have received all premium payments in full and in time and all payments have been realised and the Insured Person has given a valid and relevant Entitlement Certificate to the Network Service Provider before receiving any treatment, consultation or procedure under that Section. If the Entitlement Certificate has been used in any manner contrary to the requirements set out in the introduction to Part A, then We shall be entitled to deduct from any payment that is or may be due under Part B or any policy issued by Us and/or any premium subsequently received in respect of any policy issued by Us the value of the Entitlement Certificate and the costs and expenses as deducted by Us which We have incurred due to the unauthorised use of the Entitlement Certificate. It is agreed and understood that if We make any recovery from premium subsequently received then that premium shall be deemed to have been received short and it is further agreed and understood that the terms of this clause shall survive the termination of the Policy.
- ii.** We will only make payment under Part B to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of the death of You or an Insured Person, We will make payment to the Nominee (as named in the Schedule).
- iv.** This Policy only covers medical treatment under Part A and that part of medical treatment under Part B which is taken within India, and payments under Part B shall only be made in Indian Rupees within India.
- v.** The assignment of benefits of the policy shall be subject to applicable law.
- vi.** We are not obliged to make payment for any claim under Part B or that part of any claim under Part B that could have been avoided or reduced if the Insured Person had taken reasonable care or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

j. Change of Policyholder

If You do not renew the Policy the Insured Persons may apply to renew the Policy within 7 days of the end of the Policy Period provided that they have identified a new adult policyholder



who is a member of their immediate family. If We accept such application and the premium for the renewed policy is paid on time, then the Policy shall be treated as having been renewed without any break in cover.

SECTION E. OTHER TERM & CONDITIONS

Maxima Insurance - Schedule of Benefits

Sum Insured per Policy	1 Adult	2 Adults	2 Adults + 2 Children
Part A- Outpatient Module			
a.) Outpatient Consultations*	4 Consultations	6 Consultations	8 Consultations
b.) Diagnostic Tests#			
c.) Pharmacy#			
d.) Outpatient Dental Treatment #	Rs. 5,000	Rs. 5,500	Rs. 7,000
e.) Spectacles, Contact Lenses #			
f.) Annual Health Check-up within specified Network^	1 Entitlement Certificate	2 Entitlement Certificates	2 Entitlement Certificates

* The reimbursement against non-network Outpatient Consultations is restricted up to lower of actual expenses or Rs. 400.

The reimbursement against non-network Diagnostic Tests, Pharmacy, Outpatient Dental Treatment, Spectacles, Contact Lenses is restricted up to lower of actual expenses or the Sum Insured mentioned above.

^ One Entitlement Certificate of Annual Health Check-up includes following tests: Hb, PCV, RBC, MCHC, MCV, MCH, Total WBC, Differential Count, ESR, PLT, Peripheral Smear, Complete Urine Analysis, GTT, Serum Calcium, Serum Creatinine, Lipid Profile (Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Triglycerides, Cardiac Risk Ratio), Liver Function Test (Total Protein, Albumin, Globulin, Total bilirubin, ALT, AST, GGTP), Blood group, ECG (Resting), X-ray (chest), Ultrasound (Upper abdomen screening), Consultation by General Physician, Consultation by Gynecologist, Consultation by General Physician.

Part B-Inpatient Module

Sum Insured per Policy	300,000	300,000	300,000
1 a) In-patient Treatment	Covered		
1 b) Pre-Hospitalization	30 days; can be increased to 60 days		
1 c) Post-Hospitalization	60 days; can be increased to 90 days		
1 d) Day Care Procedures	Covered		
1 e) Domiciliary Treatment	Covered		
2a) Daily Cash for choosing	Rs.500 per day, Maximum Rs.3,000		

Shared Accommodation	
2 b) Organ Donor	Covered
2 c) Emergency Ambulance	upto Rs 2000 per hospitalisation
2 d) Daily Cash for accompanying an insured child	Rs 300 per day; Maximum Rs 9,000
3 Maternity Expenses ** Waiting Period 4 years	Normal Delivery- Rs15,000; Caesarean Delivery-Rs25, 000 (* Including Pre/Post Natal limit of Rs.1,500 and infant baby limit of Rs.2,000)
4 Newborn baby	Optional
Optional Benefit	
5 Critical Illness ** [Offered on Individual basis]	Rs 300,000
** Benefits do not dip into inpatient Sum Insured	

ANNEXURE A

List of Ombudsman

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.

Office Details	Jurisdiction of Office Union Territory, District)
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, Sonepat 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).
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, Sonepat & 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.



Office Details	Jurisdiction of Office Union Territory, District)
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 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	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bheria, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, 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, Bulandshahar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli,

Office Details	Jurisdiction of Office Union Territory, District)
	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, Vasantrao 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 <u>wards of Mumbai</u> , M/East, M/West, N, S and T."

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