HDFC ERGO General Insurance Company Limited

my:health MedisureSuper Top Up Insurance

Policy Wording

A. PREAMBLE

We will provide insurance cover to the Insured Person(s) named in the Schedule subject to Your statements in the Proposal Form, declaration and/or medical reports, payment of premium and the terms and conditions of this Policy

If during the **Policy Period**, You suffer from any Illness or Accident which requires Hospitalization as an inpatient, We will reimburse the amount of such Medical Expenses as per the benefits given under Section C – Scope of Covers, in excess of Aggregate Deductible and subject to a maximum of the **Sum Insured** as stated in the Schedule. The liability of the Company to pay the admissible Claim under that Policy Year will commence only once Aggregate Deductible has been exhausted.

B. 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.

Def 1 **We/Our/Us** means HDFC ERGO General Insurance Company Limited.

Def 2 **You/Your/Insured/Insured Person** means the person(s) named as Insured/Insured Person in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

Def 3 **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def 4 **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 5 **Alternative Treatment:** are forms of treatments other than treatment under"Allopathic" or "Modern Medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Def 6 **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 7 **AYUSH HOSPITAL** means an 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 8 **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:

PWW/Ver - 1 OCT 2020

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 9 **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 10 **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 11 **Cashless facility:** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

Def 12 **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- Internal **Congenital Anomaly: Congenital Anomaly** which is not in visible and accessible part of the body

- External **Congenital Anomaly: Congenital Anomaly** which is visible and accessible parts of the body

Def 13 **Cancellation:** defines the terms on which the Policy contract can be terminated either by the Insurer or the Insured by giving sufficient notice to other which is not lower than period of 15 days.

Def 14 **Co-payment** is acost sharing requirement under a Health Insurance policy that provides that Policy holder/Insured will bear a specified percentage of the admissible Claim amount . A co-payment does not reduce the Sum Insured.

Def 15 **Condition Precedent:** means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon

Def 16 **Commencement Date/Inception Date:** means the commencement date of this Policy as specified in the Schedule.

Def 17 **Day Care treatment:** means thosemedical treatment and/or surgical procedure which is
- undertaken under General or Local Anaesthesia in a **Hospital/Day care centre** inless 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

Def 18 **Day Care Centre:** A Day care centre means any institution established for day care treatment of illness and/or injuries or a medical set up with in a hospital and which has been registered with local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner and must comply with all minimum criterion as under:

- Has qualified nursing staff under its employment
- Has qualified medical practitioner (s) in charge
- Has fully equipped operation theater of its own where surgical procedures are carried out

Maintains daily record of patients and will make these accessible to the Insurance company's authorized personnel.

Def 19 **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def 20 **Aggregate Deductible:** is a cost-sharing requirement under thisPolicy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. An Aggregate deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalization expenses incurred which are admissible under this Policy

(and not excluded) during the Policy Year period by Insured Person (individual policy) or insured family (in case of floater policy)"

Def 21 **Dependents:** mean only the family members listed below:

i. Your legally married spouse ,
ii. Your dependent children – being your children (natural or legally adopted) aged between 3 months and 23 years, who is/are financially dependent on the primary insured or proposer and does not have his / her independent sources of income.
iii. Your parents or parents-in-law

Def 22 **Disease:** means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

Def 23 **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 24 **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 25 **Family:** means You, Your: Spouse, Dependent Children, Dependant Parents/in laws, Grand Mother, Grand Father, Grand Son, Grand Daughter, Daughter in Law, Son in law, Sister, Brother, Sister in law, Nephew, Niece

Def 26 **Disclosure to information norm:** The Policy shall be void and all Premium paid here on shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def 27 **Family Floater:** means a Policy described as such in the Schedule 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 or Your Dependents during the Policy Period.

Def 28 **Grace Period:** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

Def 29 **Hospital/Nursing Home** means any institution established for In-patient Care and **Day Care Treatment** of **Illness** and/or injuries and which has been registered as a **Hospital** with the local authorities 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 30 **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 31 **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 32 **Intensive Care Unit:** Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def 33 **Injury:** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Def 34 **In-patient:** means the person(s) named in the Schedule to this Policy who is/are admitted to Hospital/Nursing Home and stays for at least 24 hours for the sole purpose of receiving medical treatment covered under the Policy.

Def 35 **Inpatient Care:** means a treatment for which the Insured Person has to stay in a Hospital for morethan 24 hours for a covered event.

Def 36 **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 37 **Maternity expenses** means

(a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

(b) expenses towards lawful medical termination of pregnancy during the policy period.

Def 38 **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 39 **Medical Expenses/Hospitalization 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 what would have been payable if the Insured Person(s) had not been insured and no more than other hospitals or **Medical Practitioners** in the same locality would have charged for the same medical treatment.

Def 40 **Medical Advice** means any consultation or advice or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def 41 **Medically Necessarytreatment** means any treatment, tests, medication, or stay in a Hospital/ Nursing Home or part of stay in Hospital/Nursing Homewhich

- is required for the medical management of the **Illness** or **Injury** suffered by the **InsuredPerson(s)**;
- 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 42 **Migration** means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def 43 **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 44 **New born baby** means baby born during the Policy Period and is aged upto 90 days.

Def 45 **Notification of a Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def 46 **Non Network** means any **Hospital, Day Care Centre** or other provider that is not part of the Network.

Def 47 **OPD Treatment (Outpatient):** OPD treatment means the one in which the Insured visits a clinic/ Hospital or associated facility like a consultation room for a diagnosis and treatment based on the advice of a **Medical Practitioner.** The Insured is not admitted as a Day Care or Inpatient

Def 48 **Policy** means Your statements in the proposal form, this policy wording (including endorsements, if any), and the Schedule

Def 49 **Policy Period** means the period between the inception date and the expiry date of the Policy as specified in the Schedule to this Policy or the date of cancellation of this Policy, whichever is earlier.

Def 50 **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def 51 **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def 52 **Pre-existing disease** means any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
ii. For which Medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

Def 53 **Proposal Form** means the proposal and any other information given to Us by the Insured Person(s) prior to the inception of the Policy which forms the basis of this contract of Insurance.

Def 54 **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 55 **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 56 **Qualified Nurse** means a qualified person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

Def 57 **Renewal:** 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 gaining credit for **Pre-Existing Diseases**, time bound exclusions and for all waiting periods

Def 58 **Reasonable and Customarycharges** 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 the **Illness / Injury** involved.

Def 59 **Room Rent** means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the **Associated Medical Expenses**

Def 60 **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning Your details, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def 61 **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the Sum Insured representing Our maximum liability for any or all claims during the Policy Period specified in the Schedule.

In case of two year policies, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and fresh limits upto the full Sum Insured as opted will be available for the second year.

In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

Def 62 **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 63 **Unproven/Experimental treatment:** Treatment including drug experimental therapy which is not based on established medical practice in India,is treatment experimental or unproven.

C. SCOPE OF COVERS

1. In-patient Hospitalization Expenses:

If any Insured Person suffers an Illness or Accident during the Policy Period requiring Inpatient Hospitalization, We will pay the Medical Expenses incurred for

1.1 Room Rent/ Boarding & Nursing;
1.2 ICU Rent/Boarding & Nursing;
1.3 Fees of Surgeon, Anesthetist, Nurses and Specialists;
1.4 Cost of Operation Theatre, diagnostic tests, medicines, blood, oxygen and cost of prosthetic and other Medical devices or equipment if implanted internally like pacemaker during a surgical procedure.

2. Pre-Hospitalization Medical Expenses –

The **Pre Hospitalization Medical Expenses** incurred in the 30 days immediately before You were Hospitalized, provided that:

i. Such Medical Expenses were in fact incurred for the same condition requiring subsequent Hospitalization, and;

ii. We have accepted the Claim under Scope of Cover(A). “In-patient Hospitalization expenses”.

3. Post Hospitalization Medical Expenses –

The **Post Hospitalization Medical Expenses** incurred in the 60 days immediately after You were discharged, provided that:

i. Such Medical Expenses were in fact incurred for the same condition for which Your Hospitalization was required, and;
ii. We have accepted the Claim under Scope of Cover (A). ”In-patient Hospitalization expenses”.

4. Day Care treatment –

We will pay for the **Medical Expenses** under Section C.1 on **Hospitalization** of **Insured Person** in **Hospital** or **Day Care Centre** for **Day Care Treatment.**

D: EXCLUSIONS

We shall not be liable to make any payment for any claim caused by, based on, arising out of or attributable to any of the following:

1. 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 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 36 months for any **pre-existing disease** is subject to the same being declared at the time of application and accepted by Insurer.

2. 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.

- Cataract
- Hysterectomy other than for malignancy
- Uterine prolapse including any condition requiring Hysterectomy
- Polycystic Ovarian Diseases, Myomectomy for Fibroids
- Knee Replacement Surgery (other than caused by an accident)
- Osteoarthritis and Osteoporosis
- Arthritis, Arthroscopic Surgery, Rheumatism, Joint Replacement Surgery (other than caused by accident), Prolapse of Intervertibral discs(other than caused by accident)
- Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary, uro-genital and biliary systems, Benign Prostate Hypertrophy, Hydrocele
- Congenital internal anomaly
- Fistula in anus, Piles, Fissures
- Fibroids, Dilatation & Curettage for treatment purposes, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM)
- Deviated Nasal Septum, Sinusitis and related disorders
- Surgery on tonsils/Adenoids
- Gastric and duodenal ulcer, any type of Cysts/ Nodules/Polyps, and any type of Breast lumps, benign ear, Nose and Throat disorders and surgeries Chronic Nephritis and Nephropathy (Kidney diseases).

3. 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.

4. Investigation & Evaluation: Code – Excl04

d) Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
e) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. 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:

f) 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.
g) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. Obesity/Weight control: Code – Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

h) Surgery to be conducted is upon the advice of the doctor
i) The surgery/procedure conducted should be supported by clinical protocols
j) The member has to be 18 years of age or older and
k) Body Mass Index (BMI)
i. Greater than or equal to 40 or,
ii. 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

7. 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.

8. 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 removea 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**.

9. 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.

10. 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.

11. 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.

12. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences there of. **Code – Excl12**

13. 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**

14. 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**

15. Refractive Error: Code - Excl15 – Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

16. 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.

17. Sterility and Infertility: Code- Excl17 – Expenses related to sterility and infertility. This includes:

l) Any type of contraception, sterilization
m) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
n) Gestational Surrogacy
o) Reversal of sterilization

18. Maternity: Code – Excl18

p) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
q) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

19. Domiciliary hospitalization expenses

20. Co-payment: All person(s) named in the Schedule to this Policy above the age of 80 years (age last birthday) shall bear a co-pay of 10% for each and every claim.

21. Aggregate Deductible: We are not liable for Claims/ Claim amount falling within Aggregate Deductible limit as opted and mentioned on the Schedule

22. 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.

23. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.

24. Any **Insured Person's** participation or involvement in naval, military or air force operation.

25. Investigative treatment for Sleep-apnoea, general debility or exhaustion ("run-down condition").

26. Congenital external diseases, defects or anomalies,

27. Stem cell harvesting, or growth hormone therapy.

28. Dental Treatment and surgery of any kind, unless requiring **Hospitalization**.

29. 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).

30. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).

31. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

32. Preventive care, any physical, psychiatric or psychological examinations or testing if doesn't require **Hospitalization**; 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.

33. Vaccination including inoculation and immunisations (Except post bite treatment),

34. 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 is attached and also available at www.hdfcergo.com.

35. 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,

36. Treatment taken on Outpatient basis

37. The provision or fitting of hearing aids, spectacles or contact lenses.

38. 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.

39. 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.

40. 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 crutchesand oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses is attached and also available on www.hdfcergo.com.

41. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

42. Ambulance charges.

43. Costs of donor screening and organ.

44. Expenses incurred on Alternative treatments.

45. Whilst You are flying or taking part in aerial activities (including as a cabin crew) except as a bona fide passenger (fare paying or otherwise) in a regular Scheduled airline or air Charter Company.

E. CLAIMS PROCEDURE

It is a condition precedent to Our liability that upon the discovery or happening of any illness/injury that may give rise to a claim under this Policy, You shall:-

1. Claim Notification

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

Policy Number,
Name of the person(s) named in the Schedule to this Policyavailing treatment,
Nature of disease/illness/injury,
Name and address of the attending Medical Practitioner/ Hospital
Date of admission & probable date of discharge
Approximate Claim Expenses
Any other relevant information

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

In case where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer.

2. Cashless Facility for Hospitalization

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

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

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

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

v) Cashless facility for Hospitalization benefit shall be limited exclusively to Hospitalization Expenses incurred for treatment at a Network Hospital for illness or injury which are covered under the Policy and shall be extended only for Coverage mentioned under Scope of cover(A)"Inpatient Hospitalization expenses" and Scope of cover (B) "Day care Procedures"

3. Claims Processing for Reimbursement

i) After intimation as aforesaid, further submit following documents to the TPA at Your own expense within 30 days of discharge from the Hospital, the following:-

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

Pre and Post hospitalization Claims documents

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

ii) Documents pertaining to the Post-Hospitalization claim shall be submitted to the TPA within 15 days from the date of expiry of Post-Hospitalisation coverage period.

iii) At any time You may be required to authorize and permit the TPA and/or Us or anyone deputed by Us or TPA to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.

iv) You should under go medical examination by Medical Practitioner designated by Us or the TPA and the cost of such medical examination will be borne by Us.

We may carry out verification/investigation on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the assessment of loss. Verification carried out, if any, will be done by individuals or entities authorized by Us to carry out such verification/investigation(s) and the costs for such verification/investigation shall be borne by Us.

For determining the amount of admissible claim, applicable taxes prevailing at the time of the claim will be considered

as part of claim amount and Our aggregate liability, including any payment towards such Taxes shall in no case exceed the Sum Insured.

4. TPA to Pay or Reject

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

5. Representation against Rejection

Where rejection is communicated, You, may if so desired, represent to Us within 15 days for reconsideration of the decision.

6. Condition Precedent

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.

7. Claims Service Assurance

1) If You notify a cashless facility request by sending the pre-authorization form duly filled in and signed through email, fax to Us or Our representative, then within 6 hours of the actual receipt of such a request, We will respond with:

   a) Approval, or
   b) Rejection.

If such request has been notified during office hours (9am to 9 pm) on Monday to Saturday and We fail to either approve or reject or seek further information after the expiry of 6 hours from the actual receipt of the request then, We shall be liable to pay You for the delay in the following manner:

   i) For delay beyond 6 hours: Rs.1,000/-
   ii) The maximum amount that We shall be liable to pay to You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

If such request has been notified after office hours on a working day or at any time during a holiday and We fail to either approve or reject after the expiry of 8 hours from the actual receipt of the request, then We shall be liable to pay You for the delay in the following manner:

   iii) For delay beyond 8 hours: Rs.1,000/-
   iv) The maximum amount that We shall be liable to pay You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

2) In case of reimbursement claims, We shall communicate our decision on payment within 6 working days after You submit the complete details, information and document requirements in respect of the claim. If You have provided such information and documents as required by Us and We fail to communicate our decision, then We shall pay You Rs. 1,000/- for a delay beyond 6 days. The maximum amount that We shall be liable to pay You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

3) We will not be liable to make any payments under Clauses 1 and 2 above in case of any natural event or manmade disturbance which impedes Our ability to make a decision or to communicate such decision to You.

4) Any amounts paid under this Clause will not affect the Sum Insured as specified in the Schedule. Our liability to make payments under this Clause shall at all times be restricted to the amounts specified in Clause 1 and 2 above including the maximum amount specified therein and You shall not be entitled to any sum whatsoever, in excess of those amounts. Any payment made under this Clause by Us will not amount to any admission of liability for a claim notified by You. Service Assurance is applicable only to the first response on a single claim and to no subsequent correspondence.

   The above compensation shall be paid to You notwithstanding Our obligation to pay interestat a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by the Company in cases of delay in settlement of claims, as per Reg. 9(6) of IRDA (Protection of PolicyHolder's Interests) Regulations 2002

8. Claim Settlement (Provision for Penal Interest)

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents

ii. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
iii. 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 last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.
iv. However, where the circumstances of a claim warrant an investigation in the opinion of the **Company**, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the **Company** shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
v. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the **Policyholder** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.
vi. If **We**, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.
vii. If requested by Us and at **Our** cost, the **Insured Person** must submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.
viii. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess **Our** liability and quantum in respect of the claim

F. General Conditions

1.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.

2. 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.

3. 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.

4. Observance of Terms and Conditions

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

5. Reasonable Care

You shall take all reasonable steps to safeguard against any accident or illnesses that may give rise to any claim under this Policy.

6. Notice of Charge

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

7. Electronic Transactions

You agree to adhere to and comply with all such terms and conditions as We may prescribe from time to time, and hereby agree and confirm that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of this Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary

disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by You.

8. 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.

9. 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.**

10. Cancellation

i. The Policyholder may cancel this policy by giving 15days’ written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

In case of 2 year Policy;

If cancellation done before completion of 1 year: same grid as given above is applicable on first year Premium and second year Premium will be completely refunded.

If cancellation is done after completion of 1 year: same grid as given above is applicable however retention Premium onsecond year premium will be calculated on Annual Premium without long term Policy discount.

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

11. 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 fifteen 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.

12. Place/Currency: No claim shall be payable under this Policy for any treatment or expenses incurred outside India. All claims shall be payable in India and in Indian Rupees only.

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

14. Law Applicable: Laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim thereunder.

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

16. 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.

17. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for **Renewal.** However, the Company is not under obligation to give any notice for **Renewal.**
ii. **Renewal** shall not be denied on the ground that the **Insured Person** had made a claim or claims in the preceding policy years.
iii. Request for **Renewal** along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the **policy** period, the Policy shall terminate and can be renewed within the **Grace Period** of 30 days to maintain continuity of benefits without **Break in Policy**. Coverage is not available during the **Grace Period**.
v. No loading shall apply on renewals based on individual claims experience.

18. 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 45 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.

For Detailed Guidelines on Portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

19. 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 policyatleast30 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.

For Detailed Guidelines on Migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

20. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

21. Medical Underwriting

Proposers above 55 years of age and those having medical history are subject to Medical Underwriting by the Company. We reserve the right to accept such proposals on standard terms/Decline/Accept with exclusion or Premium loading (up to maximum of 100% on basic Premium).These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us.

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

1. **Non-Financial Endorsements – which do not affect the premium**

   i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
   ii. Rectification in gender of the Insured Person (if this does not impact the premium)*
   iii. Rectification in relationship of the Insured Person with the Proposer
   iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)*
   v. Change in the correspondence address of the Proposer (if this does not impact the premium)*
   vi. Change in Nominee Details
   vii. Change in Height, weight, marital status (if this does not impact the premium) *
   viii. Change in bank details
   ix. Any other non-financial endorsement

2. **Financial Endorsements – which result in alteration in premium**

   i. Change in Age/date of birth
   ii. Change in Height, weight
   iii. Addition of Insured Person (New Born Baby or newly wedded spouse)
   iv. Deletion of Insured Person on death or Marital separation
   v. Any other financial endorsement

   The Policyholder shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of Insured person.

23. Claim Settlement (Provision for Penal Interest)

i. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
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 last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate.**
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the

Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the **Company** shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the **Policyholder** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.

24. 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.

25. 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.

26. 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**.

27. Contact Us

	Within India	**Outside India**
Claim Intimation:	Service No. 022-62346234 / 0120- 62346234 **Email:** healthclaims@hdfcergo.com	**Toll Free No:** 800 08250825 **Global Toll Free No:** +800 08250825 (accessible from locations outside India only) **Landline no (Chargeable):** 0120-4507250 **Email:** healthclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh

28. Redressal of Grievance

i. If You/ Policy Holder have a grievance that You/ Policy Holder wish Us to redress, You/ Policy Holder may contact Us with the details of grievance as given below:

ii. In case of any grievance the insured person may contact the company through:
Website: www.hdfcergo.com
Customer Service Number: 022 6234 6234 / 0120 6234 6234
Contact Details for Senior Citizen: 022 6234 6234 / 0120 6234 6234
E-mail: care@hdfcergo.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at cgo@hdfcergo.com

For updated details of grievance officer, kindly refer the link:
https://www.hdfcergo.com/customer-voice/grievances

Contact Points	**First Contact Point**	**Escalation level 1**	**Escalation level 2**
Contacts us at	022 6234 6234 / 0120 6234 6234	NA	NA
Contact Point for Senior Citizen	022 6234 6234 / 0120 6234 6234	NA	NA
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
Visit us	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai-400078	Chief Grievance Officer, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai-400078

List of Ombudsman

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.

GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakh-impur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambed-karnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Morad-abad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

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