

Day2DayCare- Policy Wordings

HDFC ERGO Health 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 1 Conditions:

Claims made in respect of any of the benefits in this policy will be subject to the plan selected. However, Our maximum liability for each benefit under the selected plan 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 avail the other covered benefits under the opted plan if all of the following requirements are satisfied:

- a) The treatment, consultation or other benefits as specified in the policy is taken or undergone by the Insured Person during the Policy Period.
- b) The payment of premium in full and in time.

Section 2 Salient Features & Benefits

The Policy may be obtained by the Insured Person for his own use or for any other insured person for one of the specified treatments, consultations or other specified benefits at a clinical establishment under the sections mentioned in a) to c) below:

a) Outpatient Consultations

This benefit covers unlimited Outpatient consultations by a general Medical Practitioner(s) or a specialist Medical Practitioner(s). A maximum of upto 5 consultations can be availed in a policy year for general or specialized consultation after applying a co-pay of 20% in non network centers. The coverage under this benefit will cover consultation services availed under Allopathy, Ayurveda, Unani, Siddha and Homeopathy.

b) Diagnostics, Vaccination, Physiotherapy & Pharmacy

This benefit covers outpatient diagnostic tests including pathology and radiology, cost and administration of vaccination by a medical practitioner, physiotherapy and pharmacy expenses for treatment under Allopathy, Ayurveda, Unani, Siddha and Homeopathy. A co-pay of 20% would be applicable on the benefit limit mentioned in the schedule of benefits in non-network centres and non network pharmacies.

c) Annual Health Check-Up (Applicable to Gold Plan only)

This benefit covers a health check-up as specified in the Schedule of Benefits for the Insured Person within Network in an individual policy. 2 health check-ups would be offered in a family floater policy. In non-network centers the insured can avail the Health Check-up benefit upto a maximum of Rs 2000 per member in an Individual policy & upto Rs 4000 per policy in a Family Floater policy. For two year policy's the insured can avail one health checkup per year per member in case of Individual policy & two health check-up per year per policy for a family floater policy.

Section 3 Exclusions

a) Waiting Periods

There is no waiting period in the plan.

b) 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:

Non Medical Exclusions	<ol style="list-style-type: none"> 1. 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. 2. Intentional self-injury or attempted suicide while sane or insane
Medical Exclusions	<ol style="list-style-type: none"> 1. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code-Excl12 2. Inpatient treatment & day care procedures; 3. 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

Section 4 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) Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India

c) Insured Person

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. Any eligible person may be added at renewal after his application has been accepted by Us and premium has been received. Member addition is allowed only at renewal and not during the policy period.

Any Insured Person in the policy has the option to migrate to similar indemnity health insurance policy available with us at the time of renewal subject to underwriting with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines.

If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will refund the premium on pro rata basis received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

d) Discounts:

We will provide a Multi-Product discount of 10% on the Day2DayCare premium if it is purchased along with Easy Health, Optima Restore or Total Health Plan of sum insured Rs.3 Lacs and above and 5%

discount if purchased along with Optima Super with Deductibles of Rs.1Lac to 3 Lacs at the time of renewal or fresh policy. To avail this discount the insured persons covered under Day2DayCare policy, must be covered in the other policy as well.

The Multi product discount will not be cumulated in case an Insured person is buying multiple policies and the highest discount as per multi product discount guidelines would apply.

An additional discount of 7.5% will be provided if insured person is paying two year premium in advance as a single premium. These discounts shall be applicable at inception and renewal of the policy.

A discount of 5% on published premium will be offered, if customer buys Day2DayCare Policy through our direct channels.

e) Supporting Documentation & Examination

In case of reimbursement claims, the Insured Person shall provide Us with any documentation and information We may request to establish the circumstances of the claim under Plan its quantum or Our liability for the claim within 15 days of Our request. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include but is not limited to the following:

- i) Our claim form, duly completed and signed for on behalf of the Insured Person.
- ii) Original Bills (consultation bill; pharmacy purchase bill, physiotherapy bill, diagnostic bill, vaccination bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

The Insured Person additionally hereby consents to:

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

f) Claims Payment

- i). We will be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
- ii). We will only make payment to You under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule). The assignment of benefits of the policy shall be subject to applicable law.
- iii). 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.
- iv). 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.
- v). 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.
- vi). 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.

- vii). In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.
- g) **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.
- h) **Non-Disclosure or Misrepresentation:**
- i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:
- a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule; and
- b) the claim under such Policy if any, shall be prejudiced.
- ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;
- a) Permanently exclude the disease/condition and continue with the Policy
- b) Incorporate additional waiting period of not exceeding 4 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 g i above.

i) 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.

Detailed Guidelines on Migration are available at https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

j) 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.

k) 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 has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

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

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

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

l) 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.

m) 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.

n) Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

o) Renewal

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

- i. The Company shall endeavor 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 (Note to insurers: Insurer to specify grace period as per product design) 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.

m) 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.

n) 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.

o) Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

p) Notices

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

- i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement
- ii) Us, shall be delivered to Our address specified in the Schedule.
- iii) No insurance agents, brokers, other person/ entity is authorised to receive any notice on Our behalf.

q) 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.

r) 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.

s) Cancellation

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

1 Year Policy Period		2 Year Policy Period	
Length of time Policy in force	% of premium refunded	Length of time Policy in force	% of premium refunded
Upto 1 Month	75.00%	Upto 1 Month	87.50%
Upto 3 Months	50.00%	Upto 3 Months	75.00%
Upto 6 Months	25.00%	Upto 6 Months	62.50%
Exceeding 6 Months	Nil	Upto 12 Months	48.00%
		Upto 15 Months	25.00%
		Upto 18 Months	12.00%
		Exceeding 18 Months	Nil

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.

Note: If a customer has taken a 2 year policy upfront and makes a claim anytime during the 2 year tenure, then he is not eligible for any refund on cancellation as per our policy terms & conditions

t) 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;

u) 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.

Detailed Guidelines on Portability are available at
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

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Section 5 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:

- Def. 1. **Age or Aged** means completed years as at the Commencement Date.
- Def. 2. **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. 3. **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. 4. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.
- Def. 5. **Clinical establishment** means a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy in any recognised system of medicine established and administered or maintained by any person or body of persons, whether incorporated or not; or
A place established as an independent entity or part of an establishment referred to above in connection with the diagnosis or treatment of diseases where pathological, bacteriological, genetic, radiological, chemical, biological investigations or other diagnostic or investigative services with the aid of a laboratory or other medical equipment, are usually carried on, established and administered or maintained by any person or body of persons, whether incorporated or not and shall include a clinical establishment owned, controlled or managed by the Government or a department of the Government, a trust, whether public or private; a corporation (including a society) registered under a Central, Provincial or State Act, whether or owned by the Government; a local authority and a single doctor but does not include the clinical establishment owned, controlled or managed by the Armed forces.
- Def. 6. **Condition Precedent** Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
- Def. 7. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.
- Def. 8. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

- Def. 9. **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery
- Def. 10. **Dependent Child or Children** means Your children Aged between 91 days and 25 years at the commencement of the Policy Period if they are unmarried, still financially dependent on You and have not established their own independent households.
- Def. 11. **Dependents** means only the family members listed below:
- i) Your legally married
 - ii) Your children Aged between 91 days and 25 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 Day2DayCarePolicy, and
 - iv) Your Parent-in-law as long as Your spouse continues to be married to you and were below 65 years at their initial participation in the plan.
All Dependent parents must be financially dependent on You.
- Def. 12. **Disclosure to information norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.
- Def. 13. **Family Floater** means a Policy described as such in the Schedule where under 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. 14. **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. 15. **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 those 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. 16. **Illness** 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.
- i. 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.
 - ii. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests-it needs ongoing or long-term control or relief of symptoms-it requires your rehabilitation or for you to be specially trained to cope with it continues indefinitely-it comes back or is likely to come back.

- Def. 17. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
- Def. 18. **Insured Person** means You and the persons named in the Schedule.
- Def. 19. **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. 20. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.
- Def. 21. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.
- Def. 22. **Pre- Hospitalisation Medical Expenses** means the Medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:
- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
- Def. 23. **Post- Hospitalisation Medical Expenses** means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:
- iii. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
 - iv. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company
- Def 20. Medical Practitioner** 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 licence. 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. 24. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence;
- Def. 25. **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate

Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends;

- Def. 26. **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. 27. **Network Provider or Network centre** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility
- Def. 28. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network.
- Def. 29. **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timeliness as well as the address / telephone number to which it should be notified.
- Def. 30. **Outpatient Treatment** is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
- Def. 31. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).
- Def. 32. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.
- Def. 33. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.
- Def. 34. **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. 35. **Pathology** means laboratory testing of blood and other bodily fluids, tissues, and microscopic evaluation of individual cells
- Def. 36. **Radiology** means the branch of medicine that deals with diagnostic images of anatomic structures through the use of electromagnetic radiation or sound waves and that treats disease through the use of radioactive compounds. Radiologic imaging techniques include x-rays, CAT scans, PET scans, MRIs, and ultrasonograms
- Def. 37. **Reasonable and Customary Necessary** 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. 38. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods
- Def. 39. **We/Our/Us** means the HDFC ERGO Health Insurance Limited
- Def. 40. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section 6 Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, You can contact HDFC ERGO Health through:

- Website : www.hdfcergohealth.com
- Toll Free : 1800-102- 0333
- Fax : 1800- 425- 4077
- Courier : Claims Department,
HDFC ERGO Health Insurance Limited
Ground floor, Srinilaya - Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad-500 034

Or

Claims Department
HDFC ERGO Health Insurance Limited
iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase - III,
Gurgaon-122016, Haryana

Additional Note: Please refer to the list of empanelled network centers on our website Or the list provided in the welcome kit.

Section 7 Redressal of Grievance

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

- Our website : www.hdfcergohealth.com
- E-mail : customerservice@hdfcergohealth.com
- E-mail specific for Senior citizens : seniorcitizen@hdfcergohealth.com
- Toll Free : 1800-102-0333
- Fax : +91-124-4584111
- Courier : Any of Our Branch office or Corporate office

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:

The Grievance Cell, HDFC ERGO Health Insurance Limited, iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase - III, Gurgaon-122016, Haryana

For updated details of grievance officer, kindly refer the link:

<https://www.hdfcergohealth.com/escalate-your-case.aspx>

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.

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD - ShriKuldip Singh	Gujarat,

Office Details	Jurisdiction of Office (Union Territory, District)
Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, JeevanSoudhaBuilding, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st 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, JanakVihar 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	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).

Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.chennai@ecoi.co.in	
DELHI - ShriSudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, Delhi. New Delhi - 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	
GUWAHATI - ShriKiriti .B. Saha Office of the Insurance Ombudsman, JeevanNivesh, 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. SandhyaBaliga Office of the Insurance Ombudsman, JeevanNidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. PoonamBodra 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	West Bengal, Sikkim, Andaman & Nicobar Islands.

Office Details	Jurisdiction of Office (Union Territory, District)
Email: bimalokpal.kolkata@ecoi.co.in	
<p>LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in</p>	<p>Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.</p>
<p>MUMBAI - ShriMilind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.</p>
<p>NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in</p>	<p>State of Uttaranchal and the following Districts: of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>
<p>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</p>	<p>Bihar, Jharkhand.</p>
<p>PUNE - ShriVinaySah Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-41312555</p>	<p>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</p>

Office Details	Jurisdiction of Office (Union Territory, District)
Email: bimalokpal.pune@ecoi.co.in	

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

IRDA REGULATION NO 12: This Policy is subject to regulation 12 of IRDA (Protection of Policyholder's Interests) Regulation 2017.

Schedule of Benefits

SILVER PLAN				
	Individual	Family Floater		
	1 member	2 members	3 members	4 members
Outpatient Consultation (general & specialized)	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network
Pharmacy & Diagnostics (including Pathology; radiology; vaccination; physiotherapy)	Network - Upto Rs 5000/Year Non Network- Upto Rs. 5000/year after applying 20% co-pay	Network - Upto Rs 6000/Year Non Network- Upto Rs. 6000/year after applying 20% co-pay	Network - Upto Rs 7000/Year Non Network- Upto Rs. 7000/year after applying 20% co-pay	Network- Upto Rs 8000/Year Non Network- Upto Rs. 8000/year after applying 20% co-pay
Health check	NA	NA	NA	NA

GOLD PLAN				
	Individual	Family Floater		
	1 member	Upto 2 members	Upto 3 members	Upto 4 members
Doctor Consultation (general & specialized)	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network
Pharmacy & Diagnostics (including Pathology; radiology; vaccination; physiotherapy)	Network - Upto Rs 5000/Year Non Network- Upto Rs. 5000/year after applying 20% co-pay	Network - Upto Rs 6000/Year Non Network- Upto Rs. 6000/year after applying 20% co-pay	Network - Upto Rs 7000/Year Non Network- Upto Rs. 7000/year after applying 20% co-pay	Network- Upto Rs 8000/Year Non Network- Upto Rs. 8000/year after applying 20% co-pay
Health check	Annual Health Check Up at network centre	2 Annual Health Check-Ups at networkcentre	2 Annual Health Check-Ups at network centre	2 Annual Health Check-Ups at network centre Non-Network: Upto a

	Non-Network: Upto a maximum of Rs 2000 per member	Non-Network: Upto a maximum of Rs 4000 per policy.	Non-Network: Upto a maximum of Rs 4000 per policy .	maximum of Rs 4000 per policy.
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