DENGUE CARE - Policy Wordings

HDFC ERGO Health Insurance Limited will cover all Insured Person/s under this Policy upto the Sum Insured. The insurance cover at all times shall be governed by and shall be subject to the terms, conditions and exclusions under this Policy.

Section I. Inpatient Benefits

The following benefits are available to all Insured Persons who gets hospitalized on Inpatient care basis for suffering from Dengue fever during the Policy Period.

a. In-Patient Treatment
Treatment arising from Dengue fever where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses (Single private A/c room), nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, medicines, drugs, consumables, diagnostic procedures.
In case of admission to a room exceeding the aforesaid category, the reimbursement/payment of Room Rent charges including all **Associated Medical Expenses** incurred at Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of **Room Rent** charges
b. Pre-Hospitalization expenses
Expenses for consultations, investigations and medicines incurred upto 15 days before Hospitalisation.

c. Post-Hospitalization expenses
Expenses for consultations, investigations and medicines incurred upto 15 days after discharge from Hospitalisation.

d. Shared accommodation Benefit
If the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital, the exclusion prescribed under Section III C v) in this Policy will be waived off.

Section II. Outpatient Benefits:

The following benefits are available to all Insured Persons during the Policy Period if NS1 (nonstructural protein 1) or any equivalent test as directed by us is positive in result. Any claims made under these benefits will be subject to Out-patient Sum Insured.

a. Outpatient Consultations
Outpatient consultation from a Medical Practitioner as defined under this Policy for treatment of Dengue fever.

b. Diagnostic Tests
Outpatient diagnostic tests for Dengue fever taken by the Insured Person from a diagnostic centre

c. Pharmacy
Medicines purchased by the Insured Person from a pharmacy, provided that such medicines have been prescribed for treatment of Dengue fever by the treating medical practitioner only

d. Home Nursing
Medical Expenses for necessary medical treatment taken by the Insured Person by our empanelled medical practitioner at home for treatment of Dengue fever

Section III. Special terms and conditions

A. Waiting Period

All treatments shall be covered subject to the waiting periods specified below:
i) We are not liable for any claim arising due to treatment and admission within 15 days from policy commencement date, which shall be mentioned over schedule of policy details that will be sent to you

B. General exclusions
We will not pay for any claim in respect of any Insured Person caused by, arising from or attributable to:
i) Any Treatment other than for Dengue fever
ii) Treatment taken by following healthcare providers (Hospitals /Medical Practitioners)
   a. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.
   b. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.
   c. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by treating Medical Practitioner's prescription.
   d. Charges related to a Hospital stay not expressly mentioned as being covered in this Policy.
iii) Excluded Providers- Code – Excl11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.
iv) Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergohealth.com.

Section IV. General Conditions

a. Conditions 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 only 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 Policy Schedule shall be covered under this Policy. 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 waiver of waiting period, exclusions under that policy etc. provided the policy has been maintained without a break as per portability guidelines prescribed by IRDA.

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

d. Notification of Treatment

i) For Cashless Service:

Planned Treatment	Emergency
For any planned treatment for Dengue fever for which a claim may be made, requires Hospitalisation, HDFC ERGO Health must be notified preferably 48 hours prior to the start of the Insured Person's Hospitalisation	For any treatment for Dengue fever for which a claim may be made, requires Hospitalisation in an Emergency, HDFC ERGO Health must be notified within 24 hours of the start of the Insured Person's Hospitalisation.

ii) For Reimbursement basis

Reimbursement claims must be informed no later than 7 days of completion of such treatment, consultation or procedure. Duly signed claim form and all the information/documents mentioned should be submitted within 15 days of the occurrence of the Incident.

e. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with the list of documentation, medical records and information mentioned below and any other documentation, medical records and information that We may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the either of the Insured Person's discharge from Hospitalisation or completion of treatment or 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. List of documentation as referred above 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 with detailed breakup of charges (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
iii) Original payment receipts
iv) All original reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
v) Original Discharge Summary containing details of Date of admission and discharge detailed clinical history, detailed past history, procedure details and details of treatment taken
vi) A precise diagnosis of the treatment for which a claim is made.
vii) A detailed list of the individual medical services and treatments provided and a unit price for each.
viii) Original Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.
ix) Indoor case papers

The Insured Person will have to undergo medical examination by Our authorised Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of evaluating the admissibility of the claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

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 have 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 Policy Schedule). The assignment of benefits of the policy shall be subject to applicable law.
iii) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
iv) 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.

v) 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.

vi) 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.

vii) 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.

viii) 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 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.

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. 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

l. 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.

m. 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.

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 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.

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 Policy Schedule / endorsement
ii) Us, shall be delivered to Our address specified in the Policy Schedule.
iii) No insurance agents, brokers or other person/ entity is authorised to receive any notice on Our behalf.

q. 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 laws.

r. 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.

1 Year Policy Period	
Length of time Policy in force	**% of premium refunded**
Upto 1 Month	75.00%
Upto 3 Months	50.00%
Upto 6 Months	25.00%
Exceeding 6 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.

s. 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;

t. Wellness Offers

From time to time, we will provide insured the opportunity to purchase items or services curated by Us and related to prevention of Dengue on Our website or through other means. These items or services, which may be offered by Us or selected partners, may be offered with a discount or as part of a special scheme.

u. 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.

v. 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.

w. 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.

x. 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.

Section V. Other Important Terms You should know

The terms defined below and at other junctures in the Policy Wording 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. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

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

Def. 4. Associated Medical Expenses means cconsultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anaesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

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

Def. 6. **Cashless facility** means a facility extended by the insurer to the insured where the payments, o f the costs o f 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. 7. **Commencement Date** means the commencement date of this Policy as specified in the Policy Schedule.

Def. 8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 9. **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. 10. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 11. **Emergency Care** means management for a severe 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. 12. **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. 13. **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. 14. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum of 24 In patient care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 15. **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

a) Acute Condition means 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 means a disease, illness, or injury that has one or more o f 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 o f symptoms
— it requires your rehabilitation or for you to be specially trained to cope with it
—it continues indefinitely
—it comes back or is likely to come back.

Def. 16. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 17. **Insured Person means** You and the persons named in the Policy Schedule.

Def. 18. **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. 19. **Medical Advice** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 20. **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. 21. **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. 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. 24. **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. 25. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 26. **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.

Def. 27. **Network Provider** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured 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** means the treatment 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. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Def. 32. **Pre-existing disease** means any condition, ailment, injury or disease:

a) 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
b) 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 issued by the insurer or its reinstatement.

Def. 33. **Policy** means and includes Your statements in the proposal form (which are the basis for this Policy), this Dengue Care Policy wording (including endorsements, if any), Annexure 1 and the Policy Schedule (as may be amended from time to time).

Def. 34. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule.

Def. 35. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 36. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 37. **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 38. **Room Rent** means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

Def. 39. **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 waiting periods

Def. 40. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Def. 41. **Shared accommodation** means a Hospital room with two or more patient beds.

Def. 42. **TPA** means the third party administrator that We appoint from time to time as specified in the Policy Schedule.

Def. 43. **Unproven/Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 44. **We/Our/Us** means the HDFC ERGO Health Insurance Limited.

Def. 45. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

Section VI. 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,
  2nd & 3rd Floor, iLABS Centre, Plot No. 404-405,
  Udyog Vihar, Phase-III, Gurgaon-122016, Haryana.

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

Office Details	**Jurisdiction of Office Union Territory, District)**
AHMEDABAD - ShriKuldip Singh Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.ahmedabad@ecoi.co.in	
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, 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, 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 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - ShriSudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Delhi.

Office Details	Jurisdiction of Office Union Territory, District)
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 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, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti,

Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.lucknow@ecoi.co.in	Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
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	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
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	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.
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 - 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 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

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

Schedule of Benefits

Benefits	Sum Insured - Rs 50,000; 100,000
1 a.) **In-patient Treatment**	Covered
1 b.) Room Rent	Single private A/c room
1 c.) shared accommodation Benefit	Covered
1 d.) Pre-hospitalization	15 Days
1 e.) Post-hospitalization	15 Days
Outpatient Treatment 2 a.) Pharmacy 2 b.) Diagnostic tests 2 c.) Outpatient Consultation 2 d.) Home nursing	Rs 10,000

Annexure I
List of excluded expenses ("Non-Medical") under indemnity Policy are uploaded on our website. Please log in to www. hdfcergohealth.com

DENGUE CARE - CLAIM PROCEDURE

Please review your policy and familiarize yourself with the benefits available and the exclusions.
To help us to provide you with fast and efficient service, We kindly ask you to note the following.

1. We recommend that you keep copies of all documents submitted to HDFC ERGO Health
2. Please quote your member ID/policy number in all your correspondences.

Claim Procedure for Hospitalisation related benefits

What do I do in case of a claim or any assistance?

Intimation & Assistance	Procedure for Reimbursement of Medical Expenses	Procedure to avail Cashless facility
Please contact us atleast 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact us within 24 hours of the event. We can be contacted 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 Please use the Claim Intimation Form for intimation of a claim.	• We must be informed no later than 7 days of completion of such treatment, consultation or procedure. • Please send the duly signed claim form and all the information/documents mentioned* therein to us within 15 days of the occurrence of the Incident. 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. * Please refer to claim form for complete documentation. • If there is any deficiency in the documents/information submitted by you, we will send the deficiency letter within 7 days of receipt of the claim documents. • On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within -30 days. • The payment will be made in the name of the proposer. **Note: Payment will only be made for items covered under your policy and upto the limits therein.**	• For any emergency Hospitalisation, we must be informed no later than 24 hours after hospitalization. • For any planned hospitalization, kindly seek cashless authorization from us atleast 48 hours prior to the hospitalization. • We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents. • Please pay the non-medical and expenses not covered to the hospital prior to the discharge For details on non medical items, please refer to Annexure 1 of Policy Wordings. • In case the ailment /treatment is not covered under the

		policy a rejection letter would be sent to the provider within 6 hours. **Note:** • **Insured person is entitled for cashless only in our empanelled hospitals.** • **Please refer to the list of empanelled hospitals on our website Or the list provided in the guidebook or welcome kit.** • **Rejection of cashless in no way indicates rejection of the claim.**

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-1020-333 or log on to our website www.hdfcergohealth.com or email us at customerservice@hdfcergohealth.com