HEALTH ON

HDFC ERGO Health Insurance Limited will cover all the Insured Persons under this Policy upto the Sum Insured. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

Section I. Inpatient Benefits

The following benefits are available to all the Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or treatment defined as a Day Care Procedure or treatment defined as Domiciliary Treatment. Any claims made under these benefits will impact eligibility for Multiplier Benefit.

	We will cover the Medical Expenses for:	**We will not cover treatment, costs or expenses for*:** *The following exclusions apply in addition to the waiting periods and general exclusions specified in section V A and V C
1	a. In-Patient Treatment Treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures, prosthetic and other devices or equipment if implanted internally during a Surgical Procedure	1. **Investigation & Evaluation:** Code Excl04 a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded. b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded. 2. Treatment availed outside India 3. Treatment at a healthcare facility which is NOT a Hospital.
	b. Pre-Hospitalisation Medical expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation, c. Post-Hospitalisation Medical expenses for consultations, investigations and medicines incurred upto 180 days after discharge from Hospital.	1. Claims which have NOT been admitted under 1a) and 1d) 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required. 3.
	d. Day Care Procedures Medical treatment, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement, which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an Out-patient basis is not included in the scope of this definition.	1. Out-Patient Treatment 2. Treatment at a healthcare facility which is NOT a Hospital
	e. Domiciliary Treatment Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under	1. Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days)

Important terms You should know

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

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.

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

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.'

	any of the following circumstances: 1. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, 2. The patient takes treatment at home on account of non availability of room in a Hospital. 3. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation	a.
	f. Organ Donor: Medical treatment of the organ donor for harvesting the organ.	1. Claims which have NOT been admitted under 1a). 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
	g. Ambulance Cover: Expenses incurred on an ambulance in subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under 1a) and 1d) 2. NON registered healthcare or ambulance service provider ambulances.
	h. Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as mentioned in schedule of benefits if the Insured Person is hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.	1. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 3. Claims which have NOT been admitted under 1a).
	i. **E-Opinion in respect of a Critical Illness** We shall arrange and pay for a second opinion from Our panel of medical Practitioners, if: -The Insured Person suffers a Critical Illness during the Policy Period; and -He requests an E-opinion; and The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner. "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke.	1. More than one claim for this benefit in a Policy Year. 2. Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner

Section II. Restore Benefit		
2	If the Basic Sum Insured and multiplier benefit (if any) is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Basic Sum Insured) will be automatically available for the particular policy year, provided that: a) The Restore Sum Insured will be enforceable only after the Basic Sum Insured inclusive of the Multiplier Bonus under Section IV have been completely exhausted in that year; and b) The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section I; c) The Restore Sum Insured can be used for only future claims made by the Insured Person d) No Multiplier Bonus under Section IV will apply to the Restore Sum Insured; e) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year; f) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year. Incase Family Floater policy, Restore Sum Insured will be available for all Insured Persons in the Policy.	1. Illness/disease for which a claim has been paid in the current policy year under Section I.

Section III. Health Checkup at Renewal

At the end of each year at renewal, We will reimburse expenses incurred on preventive health check-up by an Insured Person upto the amount mentioned in the table below. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year irrespective of their claim status.

	3 lacs -5 lacs	10 lacs- 15 lacs	20 lacs - 50 lacs
Health On Individual	Upto Rs. 2500 per policy at the end of each year at renewal.	Upto Rs. 5000 per policy at the end of each year at renewal.	Upto Rs. 10000 per insured person at the end of each year at renewal.
Health On Floater			Upto Rs. 10000 per policy at the end of each year at renewal.

Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Section IV Multiplier Benefit

a) If no claim has been made in respect of Section I under this Policy and the Policy is renewed with Us without any break, We will apply a bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 50% of the Basic Sum Insured for this Policy Year. The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

b) In Family Floater policy,

   i. The multiplier benefit shall be available on floater basis and accrue only if no claims have been made in respect of any Insured Person during the expiring Policy Year.

   ii. Accrued Multiplier benefit is available to all insured persons under the policy

c) If a Multiplier benefit has been applied and a claim is made in any Policy Year, then in the subsequent Policy Year We will automatically decrease the accrued multiplier benefit at the same rate at which it is accrued. However this reduction will not reduce the Sum Insured below the basic Sum Insured of the policy, and only the accrued multiplier bonus will be decreased.

d) If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated the multiplier bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the multiplier bonus to be carried forward for credit in the Policy would be the least multiplier bonus amongst all the Insured Persons.

e) Portability benefit will be offered to the extent of sum of previous sum insured and accrued multiplier bonus, portability benefit shall not apply to any other additional increased Sum Insured.

f) In policies with a two year Policy Period, the application of above guidelines of Multiplier Benefit shall be post completion of each policy year.

Section V. Special terms and conditions

A. Waiting Period
All Illnesses and treatments shall be covered subject to the waiting periods specified below:

a. 30-day Waiting Period: Code – Excl03

I. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
II. This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.
III. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

b. Specified disease/procedure waiting period: Code – Excl02

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

Organ / Organ System	Illness	Surgeries
ENT	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation Nasal concha resection
Gynaecological	• cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibroids	• Dilatation and curettage (D&C) • Myomectomy for fibroids
Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoporosis & Osteoarthritis	• Joint replacement surgeries • Surgery for prolapsed inter vertebral disk
Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus • Ulcer and erosion of stomach and duodenum • Gastro Esophageal Reflux Disorder (GERD) • All forms of cirrhosis	• Cholecystectomy • Surgery of hernia

	(Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses	
Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary Bladder stone • Benign Hyperplasia of prostate	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
Eye	• Cataract	• Nil
Others	• NIL	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/organs/disciplines whether or not described above)	• Internal tumors, cysts, nodules, polyps, skin tumors	• Nil

c. Pre- Existing Diseases: Code- Excl01

i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the Policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. General exclusions

We will not pay for any claim in respect of any Insured Person , caused by, arising from or attributable to:

Non Medical Exclusions	i) War or similar situations: Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. ii) 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. iii) Intentional self-injury or attempted suicide while sane or insane iv) Hazardous or Adventure sports: **Code** – Excl09

	Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
Medical Exclusions	ii. **Investigation & Evaluation:** Code Excl04 a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded. b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded. iii. **Rest Cure, rehabilitation and respite care**–Code – Excl05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes: a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons. b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs. iv. **Obesity/Weight control:** Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: a. Surgery to be conducted is upon the advice of the doctor b. The surgery/procedure conducted should be supported by clinical protocols c. The member has to be 18 years of age or older and d. Body Mass Index (BMI) i. Greater than or equal to 40 or, ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: 1. Obesity related cardiomyopathy 2. coronary heart disease 3. severe sleep apnoea 4. uncontrolled type2 diabetes v. **Change-of-Gender treatments -** Code – Excl07**:**Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. vi. **Cosmetic or plastic surgery:** Code – Excl08:Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of **Medically Necessary Treatment** to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending **Medical Practitioner.** vii. **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. viii. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12 ix. 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 x. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a **Medical Practitioner** as part of **Hospitalization** claim or day care procedure.Code – Excl14 xi. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15 xii. **Unproven Treatments–** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.Code – Excl16 xiii. **Sterility and Infertility –**Code – Excl17 -Expenses related to sterility and infertility. This includes: a. Any type of contraception, sterilization b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI c. Gestational Surrogacy d. Reversal of sterilization xiv. **Maternity:**Code – Excl18 a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period. xv. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, **Nuclear**, **Chemical** or **Biological** attack or weapons, radiation of any kind. xvi. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound. xvii. Any **Insured Person**'s participation or involvement in naval, military or air force operation. xviii. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition"). xix. Congenital external diseases, defects or anomalies, xx. Stem cell harvesting. xxi. Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except

		treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
	xxii.	Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).
	xxiii.	Any Convalescence, ,sanatorium treatment, private duty nursing or long-term nursing care.
	xxiv.	Preventive care,and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
	xxv.	Vaccination including inoculation and immunisations (Except post Animal bite treatment),
	xxvi.	**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.
	xxvii.	Treatment taken on Outpatient basis
	xxviii.	The provision or fitting of hearing aids, spectacles or contact lenses.
	xxix.	Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces,any non-surgical hair replacement methods, Optometric therapy.
	xxx.	Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.
	xxxi.	Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergohealth.com
	xxxii.	Any Claim arising due to Non-disclosure of Pre-existing **Illness** or Material fact as sought to be declared on the Proposal form.
	xxxiii.	Non-allopathic treaments

Section VI. 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. 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.

c. Policy Period
The premium for the policy will remain the same for the policy period as mentioned in policy schedule. The policy will be issued for a period for 1 or 2 year(s) period based on Policy Period selected and mentioned on the Policy Schedule, the sum insured & benefits will be applicable on Policy Year basis.

d. Geography

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

e. Insured Person

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. may be added during the Policy Period after his application has been accepted by Us and additional premium has been received on pro-rata basis. Mid term addition is allowed only for newly married spouse or newborn children, legally adopted child after waiting period and child > 91 days not covered earlier Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

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 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.

An insured person who is covered as child dependent in the policy will be offered a separate individual policy at renewal with all continuity benefits on completion of 25 years.

f. Loadings & Discounts

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

We will inform You about the applicable risk loading or exclusion or both as the case may be through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days. We will issue Policy only after getting Your consent and additional premium (if any). Please visit our nearest branch to refer our underwriting guidelines if required.

We will provide a Family Discount of 10% if 2 or more family members are covered under a single Health On Policy. 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

Pl Note:
The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section V A i),ii) & iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

g. Notification of Claim

	Treatment, Consultation or Procedure:	HDFC ERGO Health must be notified:

i)	Any treatment for which a claim may be made requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	Any treatment for which a claim may be made requires Hospitalisation in an Emergency:	Within 24 hours of the start of the Insured Person's Hospitalisation.

f. Cashless Service:

	Treatment, Consultation or Procedure:	**Treatment, Consultation or Procedure Taken at:**	**Cashless Service is Available:**	**Notice period for the Insured Person to take advantage of the cashless service*:** *Written notice must be accompanied by full particulars.
i)	Any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	Any treatment, consultation or procedure for which a claim may be made taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours of the start of the Insured Person's Hospitalisation.

g. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with any documentation, medical records and information 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 Our request or the Insured Person's discharge from Hospitalisation or completion of treatment.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 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 reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
v) Discharge Summary containing details of Date of admission and dischargedetailed clinical history, detailed past history, procedure details and details of treatment taken
vi) Invoice/Sticker of the Implants.
vii) A precise diagnosis of the treatment for which a claim is made.
viii) A detailed list of the individual medical services and treatments provided and a unit price for each.
ix) 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.
x) Obs history/ Antenatal card
xi) Previous treatment record along with reports, if any

xii) Indoor case papers
xiii) Treating doctors certificate regarding the duration & etiology
xiv) MLC/ FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent, in case of Accidental injury

h. 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 processing any claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

i. 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. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule)..
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) Provision for Penal Interest
    a. 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.
    b. 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.
    c. 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.
    d. 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.
v) In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available sum insured 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.
vi) The Assignment of benefits of the policy shall be subject to applicable law

j. 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.

k. 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:

i. 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
ii. 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;

i. Permanently exclude the disease/condition and continue with the Policy
ii. 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.
iii. Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

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

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.

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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 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 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. 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.

q. 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.

r. Portability

The **Insured Person** will have the option to port the Policy to other insurers by applying to such **Insurer** to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

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s. 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.

t. 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.

u. 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.

v. Cancellation

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		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.

i) 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.

w. 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;

x. Moratorium Period

After completion of eight continuous years under this **Policy** no look back would 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 eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this Policy shall be contestable except for proven fraud & permanent exclusions specified in the policy contract. The Policy would however be subject to all limits, sub limits, co-payments, Deductibles as per the policy contract.

y. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on Portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Procedure to avail Portability:

i. The **Portability** of Policy can be availed of by submitting the completed Proposal form, portability annexure along with previous policy documents and **Renewal** notice of expiring policy, at least 45 days in advance, but not earlier than 60 days, from the expiry of the existing health insurance policy.
ii. Policy can be ported on at the time of **Renewal** of the existing health insurance policy.
iii. Waiting period credits shall be extended to **Pre-Existing Diseases** and time bound exclusions/waiting periods.
iv. If the proposed **Sum Insured** is higher than the **Sum insured** under the expiring Policy, all waiting periods under Section E shall be applicable on the increased Sum Insured.
v. Portability shall be applicable to the Sum Insured under previous Policy and to the Cumulative Bonus acquired under that Policy
vi. We will process **Portability** application within 15 days of receiving the complete proposal form and Portability Form.

z. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on Migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

aa. 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.

Section VII. 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. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an **Insured Person** participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

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

Def. 4. **Alternative treatments** means forms of tre**atments other** than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the In**d**ian context

Def. 5. **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. 6. **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. 7. **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. 8. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 9. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 10. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position

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

Def. 11. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def. 12. **Copayment** 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. 13. **Cumulative Bonus (Multiplier Benefit)** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 14. **Critical Illness means** Cancer of specified severity, Open Chest CABG, First Heart Attack of specified severity, Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs, Stroke resulting in Permanent Symptoms as defined below only:

i) ***Cancer of specified severity****:*

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

ii) ***Open Chest CABG***:

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

II. The following are excluded:

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

iii) ***First Heart Attack of Specified Severity***:

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

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

iv) **Kidney Failure requiring Regular Dialysis:**

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

v) ***Major Organ/ Bone Marrow Transplant:***

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

The following are excluded:

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

vi) ***Multiple Sclerosis with Persisting Symptoms***:

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

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

vii) ***Permanent Paralysis of Limbs***:

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

viii) ***Stroke resulting in Permanent Symptoms***:

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. **The following are excluded:**

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

Def. 15. **Day Care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—
-has qualified nursing staff under its employment;
-has qualified medical practitioner/s in charge;
-has a fully equipped operation theatre of its own where surgical procedure are carried out;
-maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 16. **Deductible** means a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def. 17. **Dental treatment** means treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

Def. 18. **Dependents** means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;
ii) Your children Aged between 91 days and 25 years if they are unmarried
iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Health On Policy.
iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Health On Policy.

All Dependent parents must be financially dependent on You.

Def. 19. **Dependent Child** means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 20. **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. 21. **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. 22. **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. 23. **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. 24. **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. 25. **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. 26. **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

b) 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.

c) Chronic Condition means 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
—it continues indefinitely
—it comes back or is likely to come back.

Def. 27. **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. 28. **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. 29. **Insured Person means** You and the persons named in the Schedule.

Def. 30. **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. 31. **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. 32. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 33. **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.

a) 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

b) 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. 34. **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. 35. **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. 36. **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. 37. **Non Network means** any Hospital, day care centre or other provider that is not part of the Network

Def. 38. **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. 39. **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. 40. **Pre-existing Condition means any condition, ailment, injury, or disease:**

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

Def. 41. **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. 42. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 43. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 44. **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. 45. **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. 46. **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. 47. **Room Rent** means the amount charged by a hospital for the occupancy of a bed on per day (24 hrs) basis and shall include associated medical expenses

Def. 48. **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. 49. **Surgery** or **Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 50. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 51. **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. 52. **We/Our/Us** means the HDFC ERGO Health Insurance Limited.

Def. 53. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section VIII. 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

Section IX. Grievance Redressal Procedure
In case of any grievance the insured person may contact the company through

- Our website : www.hdfcergohealth.com
- E-mail :**customerservice@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 Ltd., 2nd and 3rd Floor, iLABS Centre, Plot No 404-405, Udyog Vihar, Phase III, Gurgaon, Haryana-122016.

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 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	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19	Karnataka.

Office Details	Jurisdiction of Office Union Territory, District)
Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	
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).

Office Details	Jurisdiction of Office Union Territory, District)
DELHI - ShriSudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - 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.	West Bengal, Sikkim, Andaman & Nicobar Islands.

Office Details	**Jurisdiction of Office Union Territory, District)**
Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	
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	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, 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	Bihar, Jharkhand.

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

Health On Individual

Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00	20.00,25.00,50.00
1a) In-patient Treatment	Covered	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 Days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered
1f) Organ Donor	Covered	Covered
1g) Ambulance Cover	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation
1h) Daily Cash for choosing Shared Accommodation	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered
2) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
3) Health Checkup at renewal	3 lacs;5 Lacs: Upto Rs. 2500 per policy at the end of each year at renewal. 10 lacs/15 lacs: Upto Rs. 5000 per policy at the end of each year at renewal.	Upto Rs. 10000 per insured person at the end of each year at renewal.
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal

Health On Family

Basic Sum Insured per Policy per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00,15.00	20.00,25.00,50.00
1a) In-patient Treatment	Covered	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 Days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered
1f) Organ Donor	Covered	Covered
1g) Ambulance Cover	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation
1h) Daily Cash for choosing Shared Accommodation	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered
2) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
3) Health Checkup at Renewal	3 lacs;5 Lacs: Upto Rs. 2500 per policy at the end of each year at renewal. 10 lacs/15 lacs: Upto Rs. 5000 per policy at the end of each year at renewal.	Upto Rs. 10000 per family at the end of each year at renewal.
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal