CRITICAL ADVANTAGE RIDER

It is agreed and understood that the Critical Advantage Rider can only be bought along with the Base Plan and cannot be bought in isolation or as a separate product. The Critical Advantage Rider is subject to the terms and conditions stated below and the Policy terms, conditions and applicable endorsements of the Base Plan. The Critical Advantage Rider shall be available only if the same is specifically mentioned in the Schedule of Insurance Certificate.

The following benefits are available to all Insured Persons who suffer an Illness during the Policy Period which requires Hospitalisation on an Inpatient basis. Any claims made under these benefits will impact eligibility for renewal benefit in the Base Plan.

Section A. Definitions

The terms defined in the Base Plan 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. All terms are subject to the terms defined in the Base Plan and additional terms defined below.

I. Standard Definitions

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. 1. **Pre-existing Disease** means any condition, ailment, injury or disease:

-that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

-for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

II. Specific Definitions

Def.1 **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def.2 **Base Plan** means any retail indemnity health Insurance policy issued by HDFC ERGO General Insurance Company Limited including its terms and conditions, any annexure thereto and the Policy Schedule (as amended from time to time), the information statements in the proposal form and the Policy wording (including endorsements, if any) and to which this Rider is attached.

Def.3 **Break in policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Def.4 **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. 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. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def.5 **Hospital (overseas)** means a private or public organization legally authorized to provide medical treatment for Illnesses or bodily Injuries, equipped with the material/technological means and adequate staff to provide diagnosis and surgical interventions, and attended by Doctors and medical staff 24 hours a day.

Def.6 **Preliminary Medical Certificate:** Written approval, issued by Us which includes confirmation of cover under the Policy prior to the services being performed in the indicated Hospital, outside of India, for any treatment, services, supplies or prescriptions relating to a Claim.

Def.7 **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.8 **Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Section B. Major Illnesses Covered

Following are the major illnesses covered under the rider.

a. Cancer Treatment:

The treatment of:

1. Any malignant tumour including leukaemia, sarcoma and lymphoma (except cutaneous lymphoma), characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissues;
2. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.
3. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia

b. Coronary Artery by-pass surgery:

The undergoing of Surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

Special Exclusions under Coronary Artery by-pass surgery:

Any coronary disease treated using techniques other than the by-pass of the coronary arteries, like any kind of angioplasty Surgery.

C. Heart Valve replacement or repair:

I. The undergoing of Surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

D. Neurosurgery:

Covers:

1. Any Surgical intervention of the brain or any other intracranial structures;
2. Treatment of benign tumours located in the spinal cord.

e. Live-donor organ transplant:

Meaning a Surgical transplant in which the Insured receives a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.

Special Exclusions for Live-donor organ:

i) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease.

ii) Any transplant when the transplant is conducted as a self-transplant.
iii) Any transplant when the Insured is a donor for a third-party.
iv) Any transplants from a dead donor.
v) Any organ transplant that involves Stem Cells treatment.
vi) The transplant made possible by the purchase of donor organs.
vii) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a major illnesses covered under the rider.

f. Bone Marrow Transplant:
Meaning Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from:
1. the Insured (Autologous bone marrow transplant); or
2. from a living compatible donor (allogeneic bone marrow transplant).

g. **Aorta Graft Surgery** means the actual undergoing of surgery of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.
Realisation of the aortic surgery has to be confirmed by a specialist Medical Practitioner (Cardiologist/Cardiac Surgeon).

h. Pulmonary artery graft surgery -The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

Section C. Benefits
The following benefits are available to Insured Person who suffers above listed major illness during the Policy Period which requires Hospitalisation on an Inpatient basis up to the sum insured specified in Policy Schedule of the Base Plan.

a. In-Patient Treatment

Medical Expenses for:
i) Room rent, boarding expenses,
ii) Nursing,
iii) Intensive care unit,
iv) Medical Practitioner(s),
v) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
vi) Medicines, drugs and consumables,
vii) Diagnostic procedures,
viii) The Cost of prosthetic and other devices or equipment if fully inserted into the body or treatment of any medical disorder, and required for medical procedure arranged and paid for by this rider
ix) Transfers and transportation by ground or air ambulances where their use is indicated and prescribed by medical practitioner and pre-approved by us
x) For Medication applied by medical prescription while the Insured is Hospitalized for treatment of a Covered Illness or Medical Procedure. Medication prescribed for post-operative treatment are covered for 30 days from the date the Insured has completed the stage of the treatment received out of India and only when these are purchased prior to returning to India.
xi) For services provided to a living donor during the process of removal of an organ to be transplanted to the Insured, arising from:
- The investigation procedure for the location of potential donors;
- Hospital services provided to the donor, including accommodation in a Hospital room, ward or section, meals, general nursing services, regular services provided by Hospital staff, laboratory tests and use of equipment and other Hospital facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted);

- For Surgery and medical services for the removal of a donor's organ or tissue to be transplanted to the Insured.

xii) For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to the Insured. Cover will only be provided for expenses incurred from the date of issue of the Preliminary Medical Certificate.
Note: Pre hospitalisation expenses are not covered under this rider.

Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.

b. Post-Hospitalization expenses for consultations, investigations and medicines incurred upto 30 days after discharge from Hospitalisation.

c. Travel Expenses

We will arrange and pay for travelling expenses of the Insured, one travelling companion and the living donor in the case of transplant with the sole purpose of receiving treatment as approved by Us in the Preliminary Medical Certificate.

In the event that the Insured changes the travel dates from those communicated by Us, the Insured will need to compensate Us for all the associated costs of organizing and providing new travel arrangements, unless the changes have been made necessary from a medical standpoint.

The travel expenses covered will include:

i) Transportation from the Insured's permanent address to the designated airport or international rail station.

ii) Economy class air ticket to the city of treatment destination and the transportation to the designated hotel.

iii) Transportation from the designated Hotel or Hospital to the designated airport or international rail station.

iv) Economy class rail or air ticket and subsequent transportation to the city of the Insured's permanent address.

d. Accommodation Expenses

We will arrange and pay for the accommodation, outside India, of the Insured, one travelling companion and the living donor in the case of transplant, with the sole purpose of receiving treatment as approved by Us in the Preliminary Medical Certificate.

We will be responsible for deciding the accommodation booking dates based on the approved treatment schedule. These dates will be communicated to the Insured to allow for sufficient time for the Insured to make all the necessary personal arrangements.

We will provide a return date based on the completion of the treatment and the agreement with the treating Medical practitioner that the Insured is fit to travel.
In the event that the Insured changes the dates of travel from those booked and communicated by Us, the Insured will need to compensate Us for all the associated costs of organizing and providing new accommodation arrangements, unless the changes have been made necessary from a medical standpoint.

The accommodation arrangements will include bookings for a double room or twin bed room in a three or four star hotel. (The choice of hotel will be subject to availability and based on the proximity to the hospital or treating medical practitioner within a radius of 10 km.)

The accommodation arrangements exclude Breakfast, meals and incidental costs at the hotel, and any upgrades to the hotel room.

We will take due care in booking the reasonable accommodation, but We will not be responsible for quality of services or deficiency of services that may occur in the particular accommodation

e. Repatriation Expenses

In the event the Insured (and/or living donor in the case of transplant) dies outside India while receiving the treatment approved by Us in the Preliminary Medical Certificate, we will pay for the repatriation of the deceased's remains to India.

This coverage is limited to only those services and supplies necessary to prepare the deceased´s body and to transport to India, including:

i) The services provided by the funeral company providing the international repatriation, including embalmment and all administrative formalities.

ii) The minimum obligatory coffin.

iii) The transport of the deceased's remains from the airport to the designated place of burial in India.

f. Second opinion in respect of major illness

We shall arrange for a second opinion from Our panel of Medical Practitioners, if the Insured suffers any listed major illness detailed in Section B during the Policy Period.

Section D. Exclusions & Waiting Period

The Critical Advantage Rider is subject to the terms and conditions stated below and the Policy terms, exclusions and conditions of the Base Plan.

A. Standard Waiting Period

All 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:

Sl No	Organ / Organ System	Illness	Surgeries
a.	ENT	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Nasal concha resection
b.	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease • Fibroids (fibromyoma)	• Dilatation and curettage (D&C) • Myomectomy for fibroids
c.	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis	• Surgery for prolapsed inter vertebral disk • Joint replacement surgeries
d.	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 (Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses	• Cholecystectomy • Surgery of hernia
e.	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	• Cataract	• NIL
g.	Others	• NIL	• Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/ organs/ disciplines whether or not	• Internal tumors, cysts, nodules, polyps, skin tumors	• NIL

	described above)		

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

B. Exclusions

All other general exclusions as mentioned in the Base Plan unless otherwise stated in Section B of Critical Advantage Rider policy wordings.

Section E. General Terms & Conditions

I. Standard General Terms & Conditions

a. 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.

b. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges **or**
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

c. 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.

d. 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.

e. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

f. Renewal of Policy

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to conditions stated under Moratorium clause

i. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.
ii. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
iii. No loading shall apply on renewals based on individual claims experience
iv. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.
v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

g. 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.

h. 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.

i. Cancellation:

i The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

1. The Company may cancel the Policy at any time on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud or non-disclosure or misrepresentation
2. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s
3. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

j. 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.

k. 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.

l. 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.

m. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

n. 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.

o. Redressal of Grievance

In case of any grievance the insured person may contact the Company through:

- Website: www.hdfcergo.com
- Contact us : 022 6234 6234 / 0120 6234 6234
- E-mail: grievance@hdfcergo.com
- Contact Details for Senior Citizen: 022 – 6242 – 6226
- E-mail specific for Senior citizens : seniorcitizen@hdfcergo.com

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

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

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contact us at	https:// www.hdfcergo.com/ customer-care/ grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/ customer-care/grievances/ escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/ customer-care/grievances/ escalation level 2 Call - : 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	022 – 6242 – 6226 | seniorcitizen@hdfcergo .com	022 – 6242 – 6226 | seniorcitizen@hdfcergo.com	022 – 6242 – 6226 | seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
Visit us	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai-400078	The Chief Grievance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System -https://bimabharosa.irdai.gov.in/.

Latest contact details of Offices of Insurance Ombudsman are provided at Annexure A.

Section F. Other Terms & Conditions

1. Other Conditions

This rider will be offered if base policy Sum Insured is Rs. 10 lacs & above. If this rider is opted, separate sum insured will be displayed on base policy schedule

The Object of this rider is to provide the Insured with cover for the services and medical expenses in respect of treatment for Major Illnesses Covered, when all the following conditions are met:

i. The procedure is performed during the period of cover;
ii. The diagnosis leading to the medical procedure is confirmed by Us;
iii. The treatment is Medically Necessary;
iv. The expenses are within the Sum Insured and limits stated in the Policy Schedule;
v. The treatment is arranged by Us accordance with the Claims Procedure set out in Section E
vi. The medical expenses arise outside India.
vii. The expenses for any diagnostic procedures, treatment, services, supplies or prescriptions are covered by this rider as stated in Section C

2. Claim Procedure

i. Insured must notify Us of the claim for any of the listed major illnesses and submit all relevant documents for that claim.

ii. After assessing the documents, We will inform the Insured about eligibility of the claim. If the claim is eligible, We will provide our recommendation for treatment with a list of recommended Hospitals to the Insured.
iii. On receipt of the Insured's confirmation of his/her decision to receive treatment abroad at a Hospital selected from the list of recommended Hospitals for treatment, We will organize the necessary logistical and medical arrangements for the correct admission of the Insured and will issue a Preliminary Medical Certificate valid only for that Hospital.

Note:

i. We will provide coverage only in the indicated hospital in the Preliminary Medical Certificate. Any expense incurred in a different Hospital from the one mentioned in the Preliminary Medical Certificate will not be covered.
ii. Any expense incurred before the issuance of the Preliminary Medical Certificate will not be covered.
iii. The list of recommended Hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured at the time of issue of Preliminary Medical Certificate. Since the health condition of the Insured may change over time, both documents will have a validity of three months. In the event that the Insured does not select a Hospital from the list of recommended Hospital or does not initiate treatment within 3 months of issuance of Preliminary Medical Certificate within 3 months of issue, we will reissue these documents based on the health condition of the Insured at that time.
iv. Reimbursement of expenses is not allowed under Critical Advantage rider as this rider is meant to cover planned treatment outside India and does NOT cover emergencies occurring while the Insured is overseas.

3. Claim Related Information

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

	Within India
Claim Intimation:	Customer Service No. 022-62346234 / 0120-62346234 Email: healthclaims@hdfcergo.com Reimbursement Claim Intimation: Visit www.hdfcergo.com - > Help - > Claim Registration
Claim document submission at address:	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360

Note: All other terms and conditions are subject to Policy terms, conditions and applicable endorsements of the Base Plan.

Annexure A - Contact details of Offices of Insurance Ombudsman

S.No	Office Details	Jurisdiction of Office (Union Territory,District)
1	**AHMEDABAD** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
2	**BENGALURU** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
3	**BHOPAL** Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202: Email : bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
4	**BHUBANESWAR** Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
5	**CHANDIGARH** Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
6	**CHENNAI**	Tamil Nadu, PuducherryTown and Karaikal

	Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	(which are part of Puducherry).
7	**DELHI** Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
8	**GUWAHATI** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Insurance Ombudsman 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 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
10	**JAIPUR** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.

11	**KOCHI** Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
12	**KOLKATA** Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
13	**LUCKNOW** Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, 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.
14	**MUMBAI** Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
15	**NOIDA** Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
16	**PATNA**	Bihar, Jharkhand.

	Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	
17	**PUNE** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Schedule of Benefits

Benefit	**Sum Insured**
Inpatient Treatment	Upto Sum Insured
Post Hospitalisation	
Accommodation expenses	
Travelling expenses	
Repatriation Expenses	
Second opinion for major illness	Covered