HDFC ERGO General Insurance Company Limited

Prospectus - Group Mediclaim Insurance

Key features of the policy:

1. No Entry age limit with lifetime renewal
2. Various optional covers available such as Hospital Cash, Cumulative Bonus etc.
3. 100% Sum Insured Restore Benefit available.
4. PED coverage after 48 months.
5. Option to pay premium in monthly, quarterly and half-yearly installments

A. Coverages

I. Hospitalization Expenses

We will pay under below listed Covers on **Medically Necessary Hospitalization** of an **Insured Person** due to **Illness** or **Injury** sustained or contracted during the **Period of Insurance** subject to terms and conditions as listed below.

a. Medical Expenses

- **i.** **Room Rent** and boarding charges
- **ii.** **Intensive Care Unit** charges
- iii. Consultation fees & Nursing charges
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
- v. Medicines, drugs and consumables
- vi. Diagnostic procedures related to admissible hospitalization claim
- vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

b. Pre-Hospitalization Medical Expenses Cover

We will pay for the **Pre-HospitalizationMedical Expenses** incurred during the 30 days immediately before **Hospitalization** of an **Insured Person.**

c. Post-Hospitalization Medical Expenses Cover

We will pay for the **Post-HospitalizationMedical Expenses** incurred upto 60 days from the date **Insured Person** is discharged from **Hospital.**

d. Domiciliary Hospitalization

We will pay the **Medical Expenses** incurred on **Domiciliary Hospitalization** of the **Insured Person** presecribed by treating **Medical Practitioner.**

e. Organ Donor Expenses

We will pay **Medical Expenses** covered under Section A.I.a towards organ donor's **Hospitalization** for harvesting of the donated organ where an **Insured Person** is the recipient subject to condition that;

- i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/or Regulations.
- **ii.** **Hospitalization** Claim under Section A.1 is admissible under the coverage for the **Insured Person**
- iii. The Organ Donor's **Pre-Hospitalization** and **Post-Hospitalization Medical Expenses** are excluded under the **Policy**.
- iv. Any other **Medical Expenses** or **Hospitalization** consequent to the harvesting is excluded under the Coverage.

f. Day Care Procedures

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

g. Road Ambulance Cover

For each admissible Claim under Section A.I.a and A.I.f, **We** will pay for expenses incurred on Road Ambulance Services if **Insured Person** is required;

- i. to be transferred to the nearest **Hospital** following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)
- ii. or from one **Hospital** to another **Hospital**
- iii. or from **Hospital** to Home (within same City) following **Hospitalization**

II. Optional Covers

Insuring Clause

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that **We** will pay/restrict the Medical Expenses under below listed Covers subject to waiting periods and limits as specified in the Schedule of Coverage on the **PolicySchedule**/Certificate of Insurance.

Subject to otherwise all other terms, conditions, exclusions and waiting periods applicable to the **Policy**.

These Covers are optional and applicable only if opted for and upto the **Sum Insured** or limits mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.

1. Pre-Existing Disease Waiting period Modification Option

   On availing this option, **Waiting Periods** listed under Section B.I.i shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   All other terms and Conditions of the **Policy** shall remain unaltered.

2. Specific Illness Waiting period Modification Option

   On availing this option, **Waiting Periods** listed under Section B.I.ii shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   All other terms and Conditions of the **Policy** shall remain unaltered.

3. Modification of General Waiting Period

   On availing this option, **Waiting Periods** listed under Section B.I.iii shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   All other terms and Conditions of the **Policy** shall remain unaltered.

4. Modification of Pre and Post Hospitalization Medical Expenses

   On availing this option, **Pre** and **Post Hospitalization Medical Expenses** limit specified under Section A.I.b and A.I.c respectively shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   All other terms and Conditions of the **Policy** shall remain unaltered.

5. Room Rent and ICU Modification Option

   On availing this option, **Room Rent** and **ICU** limitsunderSection A.I.ashall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   Proportionate Deduction

   In case **Room Rent** during **Hospitalization** of **InsuredPerson** exceeds the aforesaid limits, the reimbursement/payment of **Room Rent** charges including all **Associated Medical Expenses** incurred at **Hospital** shall be effected in the same proportion as the admissible

rate per day bears to the actual rate per day of **Room Rent** charges. This condition is not applicable in respect of **Hospitals** where differential billing for **Associated Medical Expenses** is not followed based on Room Rent.

6. Road Ambulance Modification Option

   On availing this option, Road Ambulancelimit specified under Section A.I.gshall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

7. Hospital Cash

   i. Hospital Cash

      i. If **Insured Person** contracts **Illness**or sustains **Injury**during **Period of Insurance,** which results in **Medically Necessary**;

      ii. Hospitalization

      iii. Domiciliary **Hospitalization**

      iv. **Hospitalization** for **Alternative Treatments**

      of an **Insured Person** within India, **We** will pay per day **Sum Insured** as specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurancesubject to maximum number of benefit days for each continuous and completed period of 24 hours of such **Hospitalization**.

      The payment is subject to**Time Deductible**specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   ii. Specific Conditions applicable to Hospital Cash

      For the purpose of application of **Time Deductible**,successive **Hospital**stays with less than sixty daysbetween each one for a same cause, shall be deemed as one **Hospitalization** event.

8. Preventive Health Check Up

   We will indemnify the **Insured Person** towards the cost of **Preventive Health Check – Up,** up to the limit mentioned on the Schedule of Coverage in the **Policy Schedule**/Certifiate of Insurance.

   Other terms and Conditions applicable to this Coverage

   - The Coverage will be applicable as per the eligibility as mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.
   - In case of Annual Eligibility, the percentage and limit will be calculated on expiring Coverage **SumInsured**and will be only applicable to **Insured Person** covered under expiring Coverage, subject to no claim under Base Coverage.
   - In case of Eligibility at the end of each block of continuous three years, the percentage and limit will be calculated on Average **Sum Insured** during block of three years and will be only applicable to **Insured Person** covered for all previous 3 years.
   - Claim under this Cover does not impact the **Sum Insured** or the eligibility for **Cumulative Bonus.**
   - The test reports received under this Coverage will not be utilized for re-underwriting the expiring coverage of I**nsured Person**

9. Co-Payment

   On availing this option, **Co-Payment** as mentioned in the Schedule of Coverage on the **PolicySchedule**/Certificate of Insurance will be applied on each and every admissible claim.

10. AlternativeTreatment

    We will pay **Medical Expenses** covered under Section A.I, on **Medically Necessary Hospitalization** of **Insured Person** in **Ayush Hospital** upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance for following **Alternative Treatments** prescribed by **Medical Practitioner**:

    - Ayurvedic
    - Unani
    - Siddha
    - Homeopathy

11. Deletion of Domiciliary Hospitalization

    On availing this option, Domiciliary Hospitalization under Section A.I.dshall stand deleted under the **Policy**.

12. Second Medical Opinion for Major Illness

    We will pay expenses incurred towards **Second Medical Opinion** availed from **Medical Practitioner**in respect of **Major Illness** listed below through our **Network Provider**.

    The Coverage under this benefit shall cease to exist upon availing Second Opinion for any one **Major Illness** as listed below.

Major Illness Covered	
1	Cancer of specified severity
2	Open Chest CABG
3	Myocardial Infarction(First Heart Attack of specific severity)
4	Kidney Failure requiring regular dialysis
5	Major Organ/Bone Marrow Transplant
6	Multiple Sclerosis with Persisting Symptoms
7	Permanent Paralysis of Limbs
8	Stroke resulting in Permanent Symptoms

Disclaimer –*Second Medical Opinion Services are being offered by Network providers through its portal/mail/App or what so ever electronic form to Policyholders/Insured of HDFC ERGO GENERAL INSURANCE COMPANY LIMITED. In no event shall HDFC ERGO be liable for any direct, indirect, punitive, incidental, special consequential damages or any other damages whatsoever caused to the Policyholders/Insured of HDFC ERGO while receiving the services from Network providers.*

13. Restore Benefit

    Instant addition of 100% Base **Sum Insured** on complete or partial utilization of **Your** existing **Sum Insured** and **Cumulative Bonus** (if applicable) during the **Policy Year**. The Total amount (Base **Sum Insured**, **Cumulative Bonus** and Restore **Sum Insured**) will be available to all Insured Persons for all claims under the Coverage during the current **Policy Year** and subject to the condition that single claim in a **Policy Year** cannot exceed the sum of Base **SumInsured.** and the **Cumulative Bonus** (if applicable).

    Conditions for Restore benefit:

    a. The **Sum Insured** will be restored only once in a **Policy Year**.

    b. If the Restored **Sum Insured** is not utilized in a **Policy Year**, it will expire.

    In case of a Family Floater Policy, Restore **Sum Insured** will be available on floater basis for all Insured Persons in the **Policy**.

14. Double Restore Benefit

    i. Instant addition of 100% Base**Sum Insured** on complete or partial utilization of **Your** existing **Policy Sum Insured** and **Cumulative Bonus** (if applicable) during the **Policy Year**. The Total amount (Base **Sum Insured**, **Cumulative Bonus** and Restore **Sum Insured** when added) will be available to all Insured Persons for all claims under the Coverage during the current **Policy Year** and subject to the condition that single claim in a **Policy Year** cannot exceed the sum of Base**Sum Insured** and the **Cumulative Bonus** (if applicable).

    ii. Post complete utilization of **Your**Base**Sum Insured** and **Cumulative Bonus** (if applicable), if **You** partially or completely utilize your Restore **Sum Insured** (as given in i above), another 100% of Base **Sum Insured** would be added to **Your** Restored **Sum Insured** available to all Insured Persons for claims under the Coverage during the current **Policy Year** and subject to the condition that single claim in a **Policy Year** cannot exceed the Base **Sum Insured**.

Conditions for Double Restore benefit:

a. The Restore or Double Restore **Sum Insured** will be applied only once for the **InsuredPerson** during a **Policy Year**

b. If the Restore or Double Restore **Sum Insured** is not utilized in a **Policy Year**, it shall not be carried forward to any subsequent **Policy Year**.

c. In case of a Family Floater Policy, Restore or Double Restore **Sum Insured** will be available on floater basis for all Insured Persons in the **Policy**.

d. The Restore or Double Restore **Sum Insured** can be used for claims made by the Insured Person in respect of the benefits stated in Section A.1

15. Cumulative Bonus

On each continuous **Renewal** of the Coverage with **Us**, **We** will apply percentage of Base **Sum Insured**as specified in the Schedule of Coverage in the **Policy Schedule**/Ceritficate of Insurance under expiring Cover as **Cumulative Bonus** in the Coverage provided that;

i. There has been no claim under the Coverage in expiring year.

ii. **Cumulative Bonus** will be reduced at the same rate as accrued in the event of admissible Claim under the Coverage.

iii. **Cumulative Bonus** can be accumulated upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

iv. **Cumulative Bonus** applied will be applicable only to **Insured Person(s)** covered under the expiring Coverage and who continue to remain insured on **Renewal**.

16. Maternity Cover

We will pay**Maternity Expenses** to the **Insured Person**under Section A.I.a,incurredduring the **Policy Period**.The Coverage is subject to the waiting periods and limits as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

On opting this cover, General Exclusion xv) under Section B.II. What is not Covered stands deleted.

We will not make payment for any claim in respect of any **Insured Person** caused by, arising from or attributable to any of the following unless expressly stated to the contrary in the **Policy**

i. **Pre-Hospitalization** and **Post-HospitalizationMedical Expenses** are not payable under this cover.

ii. We will not pay any expenses related to ectopic pregnancy under this cover. Ectopic pregnancy will be covered as a part of expenses under Section A.I only.

iii. Treatment for impotency, treatment to effect infertility, surrogate or vicarious pregnancy, voluntary termination of pregnancy, procedures to assist birth control, contraceptive supplies.

17. Pre and Post Natal Expenses

On availing this option, **We** will pay **MedicalExpenses** incurred during **Pre** and **Post Natal** period upto the limits mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

18. Baby Cover from Day 1

We will pay **Medical Expenses** incurred towards **Medically Necessary Treatment** of a **New Born Baby,** as advised by the treating **Medical Practitioner,** up to the limit mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

19. Infertility Cover

We will pay **Medical Expenses** under Section A.I.a incurred for infertility treatment, assisted reproductive treatments undertaken by Insured Person on advice of a **Medical Practitioner**, up to the limit mentioned in Schedule of Coverage on the **Policy Schedule**/ Certificate of Insurance. This cover is applicable for both Male and Female **Insured Person**.

On opting this cover, General Exclusion xiv) under Section B.II - What is not Covered stands deleted.

20. Personal Accident Cover

i. Accidental Death

We will pay the **Sum Insured**, as specified in the Schedule of Coverage on **Policy Schedule**/Certificate of Insurance, if **Insured Person** sustains **Injury** during the **Period of Insurance**, which shall within twelve months of its occurrence be the sole and direct cause of Death of **Insured Person.**

a. Disappearance

We will pay the **Sum Insured** in the event if Insured Person's body cannot be located within 365 Days;

a. after the forced landing, stranding, sinking or wrecking of a conveyance in which **Insured Person** was known to be a passenger during **Period of Insurance** or;

b. after and as a result of any **Catastrophic Event** during **Period of Insurance**

it shall be deemed, subject to all other terms and provisions of the Policy, that **Insured Person** shall have suffered Death due to **Accident** under the Coverage.

If at any time, after the payment of the **Accidental** death benefit, it is discovered that the **Insured Person** is still alive, claims settled in respect of Disapperance benefit shall be reimbursed in full to the **Company**.

Specific Conditions applicable to Accidental Death

The Coverage under this Section terminates on admissibility of Claim equal to the **Sum Insured**

ii. Permanent Disablement

If **Insured Person** sustains **Injury** during **Period of Insurance**, which shall within twelve (12) months of its occurrence be the sole and direct cause of Permanent Disablement, We will pay in accordance to the Benefit table below upto maximum of **Sum Insured**as mentioned in the **Schedule of Coverage** on the **Policy Schedule/**Certificate of Insurance provided such disablement is certified by the **Medical Practitioner**

i. Benefit Table A

S. No	The Disablement	% of Base Sum Insured Payable
1	**Permanent Total Disablement**	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two **Limbs** (physical severance of Limbs)	100%
4	Permanent Total **Loss of Sight** in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one **Limb** (physical severance of Limbs)	100%
6	Permanent Total **Loss of Speech**	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total **Loss of Mastication**	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out **Daily Activities** essential to life without full time assistance	100%
10	Permanent Total **Loss of Hearing** in both ears	75%
11	Permanent Total **Loss of one Limb** (physical severance of Limbs)	50%
12	Permanent Total **Loss of Sight** of one eye	50%

ii. Benefit Table B

S. No	The Disablement	% of Base Sum Insured Payable
1	**Permanent Total Disablement**	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two **Limbs** (physical severance or the total and permanent loss of use of such Limb)	100%
4	Permanent Total **Loss of Sight** in both eyes	100%
5	Permanent Total **Loss of Sight** of one eye and one Limb (physical severance or the total and permanent loss of use of such Limb)	100%
6	**Permanent Total Loss of Speech**	100%
7	Complete removal of the lower jaw	100%
8	**Permanent Total Loss of Mastication**	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out **Daily Activities** essential to life without full time assistance	100%
10	**Permanent Total Loss of Hearing** in both ears	75%
11	Permanent Total Loss of one **Limb** (physical severance or the total and permanent loss of use of such Limb)	50%
12	Permanent Total **Loss of Sight** of one eye	50%

iii. Benefit Table C

S.No	The Disablement	% of Base Sum Insured Payable
1	**Permanent Total Disablement**	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two **Limbs** (physical severance or the total and permanent loss of use)	100%
4	Permanent Total **Loss of Sight** in both eyes	100%
5	Permanent Total **Loss of Sight** of one eye and one Limb (physical severance or the total and permanent loss of use)	100%
6	**Permanent Total Loss of Speech**	100%
7	Complete removal of the lower jaw	100%
8	**Permanent Total Loss of Mastication**	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out **Daily Activities** essential to life without full time assistance	100%
10	**Permanent Total Loss of Hearing** in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total **Loss of Sight** of one eye	50%
13	**Permanent Total Loss of Hearing** in one ear	15%
14	**Permanent Total Loss of the lens in one eye**	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	
a)	All – one foot	15%
b)	Big – both joints	5%
c)	Big – one joint	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%

iv. Benefit Table D

S. No	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two **Limbs** (physical severance or the total and permanent loss of use)	100%
4	Permanent Total **Loss of Sight** in both eyes	100%
5	Permanent Total **Loss of Sight** of one eye and one Limb	100%
6	Permanent Total **Loss of Speech**	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total **Loss of Mastication**	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out **Daily Activities** essential to life without full time assistance	100%
10	**Permanent Total Loss of Hearing** in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total **Loss of Sight** of one eye	50%
13	**Permanent Total Loss of Hearing** in one ear	15%
14	**Permanent Total Loss of the lens in one eye**	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%

17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	
a)	All – one foot	15%
b)	Big – both joints	5%
c)	Big – one joint	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%
23	**Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of**	75%

Terms and Conditions applicable to Permanent Disablement

i. Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to fifty percent (50%) of the **BaseSum Insured** subject to maximum of **Sum Insured**payable for the loss of the said members.

ii. Benefit under item 23 of Table D shall be determined by the independent **Medical Practitioner**who will certify the perecentage of **BaseSum Insured** payable taking into consideration the nature of the ***Injury***and disability in conjunction with the stated percentages **BaseSum Insured**for more specific injuries shown in the Table of Benefits.

iii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.

iv. The Coverage under this Section terminates on admissibility of Claim(s) equal to the **Sum Insured**. The Company's liability during the lifetime of the Policy will not exceed the **Base Sum Insured** in respect of the Cover.

v. The total amount payable in respect of more than one disablement due to the same **Injury** is arrived at by adding together the various percentages of **Base Sum Insured** shown in the Table of Benefits subject to maximum of **Sum Insured**.

21. Corporate Buffer

On availing this option, **We** will provide for a **Corporate Buffer** up to the limits and terms as specified in the the **Policy Schedule**/ Certificate of Insurance provided that;

1. All other terms and conditions of the Policy shall remain unaltered
2. The coverage under this benefit will be applicable for **Insured Persons** who have exhausted their Sum Insured limits

22. OPD Cover

We will pay the**Medical Expenses** incurred by the Insured Person during **Period of Insurance** for a **Medically necessary OPD treatment** up to the limits and in accordance with terms as specified in the Scheulde of Coverage on the **Policy Schedule**/Certificate of Insurance.

On opting this cover, General Exclusion xxx) under Section B.II – What is not Covered, stands deleted.

23. Aggregate Deductible

On availing this option, the **Insured Person** shall bear an amount equal to the **Aggregate Deductible** specified in the **Schedule of Coverage** on **Policy Schedule/**Certificate ofInsurance for all admissible claim amounts assessed by **Us** in respect of all claims made by **Insured Person** in a **Policy Year**. The liability of the Company to pay the admissible Claim under that **Policy Year** will commence only once **Aggregate Deductible** has been exhausted.

Special Conditions applicable to this Cover

i. This Cover can be opted only at first inception of the **Policy** and is not available at **Renewal**

ii. Once the **Aggregate Deductible** option is availed by the **Insured Person**, it cannot be opted out of at subsequent **Renewal**.

24. Disease Capping

On availing this option, Claims under Section A.I.a, for specified **Illnesses** will be admissible upto to maximum of Sub-limits as mentioned in the Schedule of Coverage on the Policy Schedule.

B. What is Not Covered

We will not make payment for any claim in respect of any **Insured Person** caused by, arising from or attributable to any of the following unless expressly stated to the contrary in the **Policy**l

I. Waiting Periods

Claims under the Policy are covered subject to Waiting Period as specified below:

i. Pre-existing Diseases – Code – Excl01

a. Expenses related to the treatment of a **pre-existing disease** (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

b. In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of sum of **Sum Insured** increase.

c. If the **Insured Person** is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the **Policy** after the expiry of 48 months for any **pre-existing disease** is subject to the same being declared at the time of application and accepted by Insurer.

ii. Specified Disease/Procedure waiting period- Code – Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident**.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of **Sum Insured** increase.

c. If any of the specified disease/procedure falls under the waiting period specified for **Pre-existing diseases**, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e. If the **Insured Person** is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

Illnesses

Internal Congenital diseases	Non infective Arthritis	Pilonidal sinus
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g.Kidneystone,Urinary Bladder Stone	Benign tumors, cysts, nodules, polyps including breast lumps
Pancreatitis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors
Cataract	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Osteoarthritis and osteoporosis	Fibroids (fibromyoma)	Benign Hyperplasia of Prostate

Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy	Hernia
Dilatation and curettage (D&C)	Nasal concha resection	Surgery for prolapsed inter vertebral disc
Myomectomy for fibroids	Surgery of Genito urinary system	Surgery for varicose veins and varicose ulcers
Surgery on prostate	Cholecystectomy	Surgery for Perianal Abscesses
Hydrocele/Rectocele	Joint replacement surgeries	Surgery for Nasal septum deviation
Ligament, Tendon and Meniscal tear	Prolapsed Uterus	Rectal Prolapse
Endometriosis	Retinal detachment	Glaucoma
Varicocele	Hysterectomy	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries
Nasal polypectomy		

iii. 30-day waiting period – Code – Excl03

a. Expenses related to the treatment of any illness within 30 days from the first **Policy** commencement date shall be excluded except claims arising due to an **Accident**, provided the same are covered.

b. This exclusion shall not, however, apply if the **Insured Person** has continuous coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced **Sum Insured** in the event of granting higher **Sum Insured** subsequently.

iv. A waiting period of 48 months shall apply for all Claims under Maternity Cover (Section A.II.16)

v. A waiting period of 48 months shall apply for all Claims under OPD Cover (Section A.II.22)

II. Permanent Exclusions

We will not make any payment for any claim in respect of any **Insured Person** caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this **Policy**:

i. 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.

ii. 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.

iii. 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)

a. Greater than or equal to 40 or,

b. 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

iv. 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.

v. 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.**

vi. 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.

vii. 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.

viii. 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.

ix. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12

x. 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

xi. 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

xii. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15

xiii. **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

xiv. **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

xv. 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.

xvi. 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.

xvii. Aggregate Deductible - We are not liable for Claims/Claim amount falling within **Aggregate Deductible** limit if opted and as mentioned on the Schedule of Coverage in the **PolicySchedule**/ Certificate of Insurance.

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

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

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

xxi. Congenital external diseases, defects or anomalies,

xxii. Stem cell harvesting.

xxiii. 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).

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

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

xxvi. 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.

xxvii. Vaccination including inoculation and immunisations (Except post Animal bite treatment)

xxviii. **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.hdfcergo.com.

xxix. OPD treatment

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

xxxi. 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.

xxxii. 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.

xxxiii. 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 is attached and also available on www.hdfcergo.com

xxxiv. Any Claim arising due to Non-disclosure of **Pre-existingIllness** or Material fact as sought to be declared on the Proposal form.

HDFC ERGO General Insurance Company Limited

Notification of a Claim

Procedure	Cashless Hospitalization		Reimbursement Claims
	Emergencies	Planned	
Claim Intimation **You** shall intimate the Claims to us through any available mode of communication as specified in the **Policy**, Health Card or our Website			
Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for claim notification	1. The health card issued by Us 2. KYC documents 3. The Policy Number 4. Name of the Policyholder 5. Name and address of Insured Person in respect of whom the request is being made 6. Nature of the Illness/Injury and the treatment/Surgery required 7. Name and address of the attending Medical Practitioner 8. Hospital where treatment/Surgery is proposed to be taken or /Hospital where the Insured person is admitted 9. Proposed /Actual Date of admission 10. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.		
Claims documents to be submitted for Hospital Cash	1. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for **Hospital** cash benefit 2. First consultation letter from treating **Medical Practitioner** 3. Certificate from treating Medical Practitioner, specifying the duration and aetiology 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable		
Claims documents and procedure for Second Opinion	1. Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) 2. Select **Our** network **Medical Practitioner** from whom you would prefer to take the second opinion. (Please refer our Website or call at 24X 7 toll free line to obtain the list of **Our** panel doctors). 3. On receipt of the complete set of documents, We will forward the same to the concerned doctor. 4. The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.		
Claims documents to be submitted for Accidental Death	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Death certificate 4. Post mortem if conducted/FSL (Forensic science laboratory)report – To check for drug abuse/intoxication 5. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable		
Claims documents to be submitted for Permanent Disablement	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the **Injury**; 4. Disability certificate from a government certified **Medical Practitioner** or government **Hospital** confirming the extent and nature of disability; 5. Discharge summary from the **Hospital** Medical reports, case histories, investigation reports,treatmentpapers as applicable. 6. Letter from treating **Medical Practitioner** mentioning the reason and date for disablement and confirming the disablement. 7. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable		
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the **Insured person**(s) iii. Nature of disease/**Illness/Injury** iv. Name and address of the attending**Medical Practitioner/Hospital** v. Date of admission & probable date of discharge vi. Approximate Claim Expenses		Not Applicable
	Any other relevant information as required		

Process for pre-authorization	• On receipt of duly filled pre authorization form and other details, We may; Issue the authorization letter specifying the sanctioned amount, limitation, and non-payable items, if applicable Or • Reject the request for pre-authorization specifying reasons for the rejection.	Not Applicable
List of Claim documents	Not Applicable	As enlisted below
Condonation of Delay	If the claim is not notified/ or submitted to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control	

2. List of documents for Reimbursement Claims

i. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by **Hospital**).
ii. Government approved Photo ID & Age Proof
iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of **Hospitalization** in any non-network hospital of HDFC ERGO GIC or certificate from **Hospital** authorities providing facilities available including number of beds.
v. Discharge Card / Day Care Summary / Transfer Summary
vi. Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded
vii. Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
viii. All previous consultation papers indicating history and treatment details for current **Illness** and advice for current hospitalization.
ix. All diagnostic reports (including imaging and laboratory) along with prescription by **Medical Practitioner** and invoice / bill with receipt from diagnostic centre
x. All medicine / pharmacy bills along with prescription by **Medical Practitioner**
xi. MLC / FIR Copy – in **Accidental** cases only
xii. History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.
xiii. Copy of Death Summary and copy of Death Certificate (in death claims only)
xiv. Pre and Post-Operative Imaging reports
xv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).
xvi. Invoice for Vaccination and payment receipt
xvii. KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Claimant carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Claimant ***
xviii. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)
xix. Settlement letter(s), copy (-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of Insured Person, the same document reuqirement would be for nominee/legal heir of Insured Person(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility

i. **Cashless facility** can be availed only at **Our Network Provider**. The complete list of **Network Providers** and empanelled Service Providers is available on **Our** website and can be obtained by contacting **Us**.
ii. We reserve the right to modify, add or restrict any **Network Provider** for Cashless Facilities at **Our** sole discretion. The same shall be duly updated on **Our** website. **You** shall check the updated list of **Network Providers** before applying for Cashless Claim.
iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the **Hospitalization**/treatment, including dates**, Hospital** and locations match with the details as per Cashless authorized.
iv. **We** will make payment for the Cashless authorized amount directly to the **Network Provider**.
v. If the claim is not notified to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, **We** will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
iii. In the case of delay in the payment of a claim, the **Company** shall be liable to pay interest to the **Policyholder/Insured Person** from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.
iv. However, where the circumstances of a claim warrant an investigation in the opinion of the **Company**, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the **Company** shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
v. In case of delay beyond stipulated 45 days, the **Company** shall be liable to pay interest to the **Policyholder/Insured Person** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.
vi. If **We**, for any reason decide to reject the claim, the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.
vii. If requested by **Us,** at **Our** cost, the **Insured Person** must

submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and **We/Our** representatives must be permitted to inspect the medical and Hospitalization records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.

viii. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess **Our** liability and quantum in respect of the claim

General Conditions

1. Entry Age

Base Cover

Proposer	Adult Dependent	Child/Children
Minimum Entry Age – 18 Years Maximum Entry Age – No Limit	Minimum Entry Age – 18 Years Maximum Entry Age - No Limit	Minimum Entry Age – 91 days Maximum Entry Age - 25 years

Optional covers:

Proposer	Adult Dependent	Child/Children
Minimum Entry Age – 18 Years Maximum Entry Age – No Limit	Minimum Entry Age – 18 Years Maximum Entry Age - No Limit	Minimum Entry Age – 91 days Maximum Entry Age - 25 years

2. Type of Policy:

   Individual and Family Floater

3. Coverage for dependents:

   Floater Sum Insured Option: Self, Spouse, Dependent Children*, Dependent Parents/Parents in law and Siblings.

   *Dependent children: A child is considered a dependent for insurance purposes until his 25th birthday (even if not enrolled in an educational institution) provided he is financially dependent, on the proposer.

4. Policy period

   This policy can be issued for 1 year

5. Sum Insured Options
   - 50,000 to 10 lacs (in multiples of 50,000)
   - 15 lacs
   - 20 lacs
   - 25 lacs
   - 50 lacs

6. Sum Insured for Optional Covers

Pre and Post Hospitalization Modification Option	Pre Hospitalization – 15/30/60/90/180 days			
	Post Hospitalization – 15/30/60/90/180 days			
Room Rent and ICU Modification	Room Rent	1%/1.5%/2% of Base SI Maximum Up to – INR 3000/5000/No Cap Absolute Amount – INR 3000/5000		
	ICU	2x x= Room Rent Limit		
Road Ambulance Modification	INR 0/5000/At Actuals			
Cumulative Bonus	10% max up to 50%	10% max up to 100%		
Hospital Cash	Per day Sum Insured in □	INR 50 to 5000 (jn multiples of 50) Max No. of days - 15/30/60/90/180 Time Deductible – 24/48 hours		
Preventive Health Check Up	1% of Base Sum Insured, max upto INR 10,000			
	INR 500 to 10,000 (in multiples of 500)			
Co-Payment	5%/10%/15%/20%/25%/30%			
Restore Benefit	100% of Basic Sum Insured			
Double Restore Benefit				
PED Waiting Period Modification Option	3 years	2 years	1 year	0 Year
Specific Illness Waiting Period	2 Year	0 Year		
General Waiting Period	0 days			

Alternative Treatment	10%/20%/25%/50%/100% of Base Sum Insured
Deletion of Domiciliary Hospitalization	
Second Medical Opinion for Major Illness	
Maternity Expenses	Normal - INR 10000 / 15000 / 20000 / 25000 / 30000 / 35000 / 40000 / 50000 / 60000 / 75000 / 100000
	C-Sec - INR 10000 / 15000 / 20000 / 25000 / 30000 / 35000 / 40000 / 50000 / 60000 / 75000 / 100000
Pre and Post Natal Expenses	Base SI
Baby Cover from Day 1	Base SI
PA Cover	INR 50,000 – 50 lacs
Infertility Cover	Maternity SI/Base SI
Corporate Buffer	
OPD Cover	INR (500 to 5000) (in multiples of 500)
Aggregate Deductible	Deductible – INR 2.5 lacs/5 lacs/10 lacs/25 lacs
	Sum Insured Option: 5lacs/10lacs/15lacs/20 lacs/35 lacs/50 lacs
Corporate Buffer	

7. Pre-Policy Check Up

For Non Employer – Employee Groups

The PPC tests required will be as per the below PPC grid. This grid may be subject to change based on the company policy in future & will be guided by our experience

PED/BMI	SI	Upto 55 years	> 55 years
Yes	1-3 Lac	Tele MER followed by PPC (if Required) (Set 2)	Tele MER and PPC (Set 3)
	>4 Lac	Tele MER followed by PPC (if Required) (Set 2)	PPC (Set 3)
NO	1-3 Lac	STP	Tele MER and PPC (Set 2)
	>4 Lac	STP	PPC (Set 2)

Set 1: ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG

Set 2: ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG, HBsAg, TMT/2D Echo, USG Abdomen & Pelvis, Chest X ray, CEA

Set 3: Set 2, PSA (Males), Pap Smear & Sonomamography (Females), Micro albumin, BUN, Sr Uric Acid, ANA

Guidelines for Pre Policy Check up

- Pre Policy Check-up will be conducted at our **Network provider**
- Where ever Pre Policy Check-up is conducted at our **Network provider**, 100% of the Medical test charges will be reimbursed on acceptance of proposal. In case Customer Insists on a Check-up outside our **Network provider**, 50% of the Medical test charges will be reimbursed on acceptance of Proposal.
- If Proposal is declined post Pre Policy Check-up, 50% of the Medical test charges incurred will be reimbursed
- Medical Reports are considered valid for up to 3 months
- In case of any positive health declaration on the proposal form the relevant medical tests shall be advised in addition to the above grid tests
- In case of any additional tests advised besides the ones mentioned above,100% of the cost incurred on such test will be borne by customer

8. Non - Disclosure or Misrepresentation

i. If at the time of issuance of **Policy** or during continuation of the **Policy**, the information provided to Us in the Proposal Form or otherwise, by **You** or the **Insured Person** or anyone acting on behalf of **You** or an **Insured Person**, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the **Policy** shall be:

a. cancelled ab initio from the inception date or the **Renewal** date (as the case may be), or the **Policy** may be modified by **Us** at **Our** sole discretion, upon 15 day notice by sending an endorsement to **Your** address shown in the **Policy Schedule**/Certificate of Insurance, and

b. the claim under such **Policy** if any, shall be prejudiced.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of **Pre-existing Diseases** subject to your prior consent;

a. Permanently exclude the disease/condition and continue with the **Policy**

b. Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the **Policy**.

c. Levy underwriting loading from the first year of issuance of **Policy** or renewal, whichever is later.

The above options will not prejudice the rights of the **Company** to invoke cancellation under clause 1 i above.

9. 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**.

10. Condition Precedent to Admission of Liability

The terms and conditions of the **Policy** must befulfilled by the **Insured Person** for the **Company** to make any payment for claim(s) arising under the **Policy**.

11. 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.

12. Multiple Policies

i. In case of multiple policies taken by an **InsuredPerson** during a period from one or more insurers to indemnify treatment costs, the **InsuredPerson** 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 **InsuredPerson**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**.

13. Moratorium Period

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

14. 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**.

15. Geography

This **Policy** only covers Medical Treatment taken within India.

16. Loadings

i. **We** may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.

ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each **Insured Person**

iii. Loadings will be applied from Commencement date of the **Policy** including subsequent **Renewal**(s) with **Us** or on increased **Sum Insured**. We will not apply any additional loading on **Your Policy** premium at **Renewal** based on claim experience in **Your Policy**.

iv. **We** will inform **You** about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the **Policy** only on **Your** acceptance within 15 days of the receipt of such counter offer letter. In case, **You** neither accept the counter offer nor revert to **Us** within 15 days, **We** shall cancel **Your** application and refund the premium paid within next 7 days.

17. Renewal of Policy:

The **Company** shall be under no obligation to renew the **Policy**/ Coverage on expiry of the period for which premium has been paid. The **Company** reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This **Policy** may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The **Company**, however, shall not be bound to give notice that the **Policy** is due for **Renewal** or to accept any **Renewal** premium. Unless renewed as herein provided, this **Policy** shall automatically terminate at the expiry of the **Policy Period/ Coverage Period.**

18. Grace Period

i. A **Grace Period** of 30 days is available for Renewal of the Coverage. Any **Illness**, disease or condition contracted during **Grace Period**will not be covered and will be treated as **Pre-existing diseases**.

ii. For **Renewal** received after completion of **Grace Period**, the Coverage would be considered as fresh without any **Renewal** benefits

iii. For Policies on instalment basis, Grace Period is available as given below.

Instalment Premium Option	Grace Period applicable
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

19. 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.

20. Migration

The **Insured Person** will have the option to migrate the **Policy** to other health insurance products/plans offered by the **Company**by applying for **Migration** of the **Policy**atleast 30 days before the **Policy** renewal date as per IRDAI guidelines on **Migration**. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the **Company**, the **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Migration**.

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

21. 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

22. Endorsements

The following endorsements are permissible during the Policy Period:

Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

ii. Rectification in gender of the Insured Person

iii. Rectification in relationship of the Insured Person with the Proposer

iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)

v. Change in the correspondence address of the Insured Person/ Proposer(if this does not impact the premium)

vi. Change in Nominee Details

vii. Change in Height, weight, marital status (if this does not impact the premium)

viii. Change in bank details

ix. Any other non-financial endorsement

Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth

ii. Change in Height, weight

iii. Addition of Insured Person (New Born Baby or newly wedded spouse)

iv. Deletion of Insured Person on death or Marital separation

v. Any other financial endorsement

The **Policyholder/Insured Person**shallapply in a proposal form along with birthCertificate / marriage certificate as the case may be for addition of **Insured person**.

23. Cancellation

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

For Policies where instalment option is not availed, We will refund premium in accordance with the table below:

Month	**% Refund**
Up to 1 month	85.0%
Up to 3 month	70.0%
Up to 6 month	45.0%
Up to 12 month	0.0%

For Policies where Premium is paid by instalment, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the **PolicyYear**. For instalment after 6 months, no refund will be payable.

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

ii. The **Company** may cancel the **Policy** at any time on grounds of misrepresentation non-disclosure of **Material Facts,** Fraud by the **Insured Person** by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of **MaterialFacts** or **Fraud**.

24. Premium Payment in Instalments

If the **Insured Person** has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the **Policy Schedule**/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the **Policy**)

i. **Grace Period** as mentioned in the table below would be given to pay the instalment premium due for the **Policy.**

Options	**Installment Premium Option**	**Grace Period applicable**
Option 1	Half Yearly	30 days
Option 2	Quarterly	30 days
Option 3	Monthly	15 days

ii. During such **Grace Period**, coverage will not be available from the due date of instalment premium till the date of receipt of premium by **Company**.

iii. The **Insured Person** will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated **Grace Period**.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the **Grace Period**, the **Policy** will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The **Company** has the right to recover and deduct all the pending installments from the claim amount due under the **Policy**.

25. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

26. 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.

27. 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 **PolicySchedule**/**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**.

28. Claim Settlement (provision for Penal Interest)

i. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

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

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

29. Communication & Notice

Policy and any communication related to the **Policy** shall be sent to through electronic modes or to the address of the Insured as recorded in the **Policy**.

Section 41 of Insurance Act 1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

2. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees.

IRDAI Regulation no 5 - This policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests).

Annexure I - List of Non-Medical Expenses

S.No.	Item
S. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

S.No.	Item
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY