HDFC ERGO General Insurance Company Limited

Policy Wordings

my:health Medisure Super Top Up Insurance

CONTENTS

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SECTION A: PREAMBLE

We will provide insurance cover to the Insured Person(s) named in the Schedule subject to Your statements in the Proposal Form, declaration and/or medical reports, payment of premium and the terms and conditions of this Policy,

If during the Policy Period, You suffer from any Illness or Accident which requires Hospitalization as an inpatient, We will reimburse the amount of such Medical Expenses as per the benefits given under Section C – Scope of Covers, in excess of Aggregate Deductible and subject to a maximum of the Sum Insured as stated in the Schedule. The liability of the Company to pay the admissible Claim under that Policy Year will commence only once Aggregate Deductible has been exhausted.

SECTION B: DEFINITIONS

The terms defined below have the meanings ascribed to themwherever 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 referencesto any statutory enactment include subsequent changes to the same.

Standard

Def 1 **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def 2 **AYUSH HOSPITAL** means an AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a) Central or State Government AYUSH Hospital; or

b) Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or

c) AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def 3 **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def 4 **Any one illness** means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken

Def 5 **Cashless facility:** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

Def 6 **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- Internal Congenital Anomaly: Congenital Anomaly which is not in visible and accessible part of the body
- External Congenital Anomaly: Congenital Anomaly which is visible and accessible parts of the body

Def 7 **Cancellation:** defines the terms on which the Policy contract can be terminated either by the Insurer or the Insured by giving sufficient notice to other which is not lower than period of 15 days.

Def 8 **Co-payment** is a cost sharing requirement under a Health Insurance policy that provides that Policy holder/ Insured will bear a specified percentage of the admissible

Claim amount . A co-payment does not reduce the Sum Insured.

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

Def 10 **Day Care treatment:** means those medical treatment and/or surgical procedure which is

- undertaken under General or Local Anesthesia in a Hospital Day care centre in less than 24 hours because of technological advancement, and
- which would have otherwise required Hospitalization of more than 24 hours.

Treatment normally taken on an Out-patient basis is not included in the scope of this definition

Def 11 **Day Care Centre:** A Day care centre means any institution established for day care treatment of illness and/or injuries or a medical set up with in a hospital and which has been registered with local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner and must comply with all minimum criterion as under:

- Has qualified nursing staff under its employment
- Has qualified medical practitioner (s) in charge
- Has fully equipped operation theater of its own where surgical procedures are carried out

Maintains daily record of patients and will make these accessible to the Insurance company's authorized personnel.

Def 12 **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def 13 **Domiciliary hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

I. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

II. the patient takes treatment at home on account of nonavailability of room in a Hospital

Def 14 **Emergency Care** means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health

Def 15 **Disclosure to information norm:** The Policy shall be void and all Premium paid here on shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def 16 Grace Period: means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

Def 17 **Hospital/Nursing Home** means any institution established for In-patient Care and Day Care Treatment ofIllness and/or injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def 18 **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def 19 **Illness/ Illnesses** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

(a) Acute condition - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness/ Injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Def 20 Intensive Care Unit: Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def 21 **Injury:** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Def 22 **Inpatient Care:** means a treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def 23 **Maternity expenses** means

(a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

(b) expenses towards lawful medical termination of pregnancy during the policy period.

Def 24 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def 25 **Medical Expenses/Hospitalization Expenses:** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner as long as these are no more than what would have been payable if the Insured Person(s) had not been insured and no more than other hospitals or Medical Practitionersin the same locality would have charged for the same medical treatment.

Def 26 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def 27 **Medically Necessary treatment** means any treatment, tests, medication, or stay in a Hospital/Nursing Home or part of stay in Hospital/Nursing Homewhich

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

Def 28 Migration means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time

bound exclusions, with the same insurer.

Def 29 **Network provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

Def 30 **New born baby** meansbaby born during the Policy Period and is aged upto 90 days.

Def 31 **Notification of a Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def 32 **Non Network** means any Hospital, Day Care Centre or other provider that is not part of the Network.

Def 33 OPD **Treatment (Outpatient):** OPD treatment means the one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for a diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a Day Care or Inpatient

Def 34 **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def 35 **Pre-existing disease** means any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. For which Medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

Def 36 **Pre-Hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of dayspreceding the Hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def 37 **Post-Hospitalization Medical Expenses:** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance company.

Def 38 **Qualified Nurse** means a qualified person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

Def 39 **Renewal:** Renewal means the terms on which the contract of Insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous

for the purpose of gaining credit for Pre-Existing Diseases, time bound exclusions and for all waiting periods

Def 40 **Reasonable and Customary charges** means the charges for services or supplies, which are the standard charges for aspecific provider and consistent with the prevailing charges in the geographical area for identical or similar services,taking into account the nature of the Illness/ Injury involved.

Def 41 **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses

Def 42 **Surgery** or **Surgical** procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a medical practitioner.

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

Specific Definitions

Def 1 **We/Our/Us** means HDFC ERGO General Insurance Company Limited.

Def 2 **You/Your/Insured/Insured Person** means the person(s) named as Insured/Insured Person in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

Def 3 **Aggregate Deductible:** is a cost-sharing requirement under this Policy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. An Aggregate deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalization expenses incurred which are admissible under this Policy (and not excluded) during the Policy Year period by Insured Person (individual policy) or insured family (in case of floater policy)"

Def 4 **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def 5 **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.

Def 6 **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the Sum Insured representing Our maximum liability for any or all claims during the Policy Period specified in the Schedule.

In case of two/three year policies, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and fresh limits up to the full Sum Insured as opted will be available for the second/ third year.

In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

Def 7 **In-patient:** means the person(s) named in the Schedule to this Policy who is/are admitted to Hospital/Nursing Home and stays for at least 24 hours for the sole purpose of receiving medical treatment covered under the Policy.

Def 8 **Family Floater:** means a Policy described as such in the Schedule whereunder You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You or Your Dependents during the Policy Period.

Def 9 **Family:** means You, Your: Spouse, Dependent Children, Dependant Parents/in laws, Grand Mother, Grand Father, Grand Son, Grand Daughter, Daughter in Law, Son in law, Sister, Brother, Sister in law, Nephew, Niece

Def 10 **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

Def 11 **Alternative Treatment:** are forms of treatments other than treatment under"Allopathic" or "Modern Medicine" and includes Ayurveda, Unani, Sidha, Homeopathy, Yoga & Naturopathy in the Indian context.

Def 12 **Associated Medical Expenses** means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def 13 **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def 14 **Dependents:** mean only the family members listed below:

i. Your legally married spouse,

ii. Your dependent children – being your children (natural or legally adopted) aged between 3 months and 23 years, who is/are financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

iii. Your parents or parents-in-law

Def 15 **Disease:** means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

Def 16 **Commencement Date/Inception Date:** means the commencement date of this Policy as specified in the Schedule.

Def 17 Policy means Your statements in the proposal form,

this policy wording (including endorsements, if any), and the Schedule

Def 18 **Policy Period** means the period between the inception date and the expiry date of the Policy as specified in the Schedule to this Policy or the date of cancellation of this Policy, whichever is earlier.

Def 19 **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def 20 **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning Your details, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def 22 **Proposal Form** means the proposal and any other information given to Us by the Insured Person(s) prior to the inception of the Policy which forms the basis of this contract of Insurance.

C. BENEFITS COVERED

1. In-patient Hospitalization Expenses:

If any Insured Person suffers an Illness or Accident during the Policy Period requiring Inpatient Hospitalization, We will pay the Medical Expenses incurred for

1.1. Room Rent/ Boarding & Nursing;

1.2. ICU Rent/Boarding & Nursing;

1.3. Fees of Surgeon, Anesthetist, Nurses and Specialists;
1.4. Cost of Operation Theatre, diagnostic tests, medicines, blood, oxygen and cost of prosthetic and other Medical devices or equipment if implanted internally like pacemaker during a surgical procedure.

• Note pertaining specifically to AYUSH Treatments only:

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

2. Pre-Hospitalization Medical Expenses –

The Pre Hospitalization Medical Expenses incurred in the 30 days immediately before You were Hospitalized, provided that:

i. Such Medical Expenses were in fact incurred for the same condition requiring subsequent Hospitalization, and;

ii. We have accepted the Claim under Scope of Cover(A). "In-patient Hospitalization expenses".

3. Post Hospitalization Medical Expenses –

The Post Hospitalization Medical Expenses incurred in the 60 days immediately after You were discharged, provided that:

i. Such Medical Expenses were in fact incurred for the same condition for which Your Hospitalization was required, and;

ii. We have accepted the Claim under Scope of Cover (A). "In-patient Hospitalization expenses".

4. Day Care treatment –

We will pay for the Medical Expenses under Section C.1 on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment.

D: WAITING PERIOD & EXCLUSIONS

1. Standard Waiting Period

We shall not be liable to make any payment for any claim caused by, based on, arising out of or attributable to any of the following:

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 36 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 36 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 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.

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.

- Cataract
- Hysterectomy other than for malignancy
- Uterine prolapse including any condition requiring Hysterectomy

- Polycystic Ovarian Diseases, Myomectomy for Fibroids
- Knee Replacement Surgery (other than caused by an accident)
- Osteoarthritis and Osteoporosis
- Arthritis, Arthroscopic Surgery, Rheumatism, Joint Replacement Surgery (other than caused by accident), Prolapse of Intervertibral discs(other than caused by accident)
- Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary, uro-genital and biliary systems, Benign Prostate Hypertrophy, Hydrocele
- Fistula in anus, Piles, Fissures
- Fibroids, Dilatation & Curettage for treatment purposes, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM)
- Deviated Nasal Septum, Sinusitis and related disorders
- Surgery on tonsils/Adenoids
- Gastric and duodenal ulcer, any type of Cysts/Nodules/ Polyps, and any type of Breast lumps, benign ear, Nose and Throat disorders and surgeries Chronic Nephritis and Nephropathy (Kidney diseases).

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.

2. Standard Exclusions

i. Investigation & Evaluation: Code – Excl04

d) Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.

e) 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:

f) 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.

g) 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:

h) Surgery to be conducted is upon the advice of the doctor

i) The surgery/procedure conducted should be supported by clinical protocols

j) The member has to be 18 years of age or older and

k) Body Mass Index (BMI)

i. Greater than or equal to 40 or,

ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity related cardiomyopathy
2. coronary heart disease
3. severe sleep apnoea
4. uncontrolled type2 diabetes

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 removea 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: Code11** - 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. Refractive Error: Code - Excl15 – Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

xiii. Unproven Treatments: Code – Excl16 – 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.

xiv. Sterility and Infertility: Code- Excl17 – Expenses related to sterility and infertility. This includes:

l) Any type of contraception, sterilization

m) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

n) Gestational Surrogacy

o) Reversal of sterilization

xv. Maternity: Code – Excl18

p) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

q) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.

3. Specific Exclusions

1. Domiciliary hospitalization expenses

2. Co-payment: All person(s) named in the Schedule to this Policy above the age of 80 years (age last birthday) shall bear a co-pay of 10% for each and every claim.

3. Aggregate Deductible: We are not liable for Claims/Claim amount falling within Aggregate Deductible limit as opted and mentioned on the Schedule

4. War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection,military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

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

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

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

8. Congenital external diseases, defects or anomalies,

9. Stem cell harvesting.

10. Investigative treatment for analysis and adjustments of spinal subluxation, 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).

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

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

13. 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.

14. Vaccination including inoculation and immunisations (Except post bite treatment),

15. 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 etc. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.

16. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family, or stays with him,

17. Treatment taken on Outpatient basis

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

19. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement method. Optometric therapy.

20. 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.

21. 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, wheel chairs 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.

22. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

23. Ambulance charges.

24. Costs of donor screening and organ.

25. Expenses incurred on Alternative treatments except to the extent of coverage provided for under 'In-patient Hospitalization expenses' cover.

26. Whilst You are flying or taking part in aerial activities (including as a cabin crew) except as a bona fide passenger (fare paying or otherwise) in a regular Scheduled airline or air Charter Company.

E. GENERAL TERMS & CLAUSES

I. Standard Terms & Clauses

1. 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.

2. Condition Precedent to Admission of Liability

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

3. 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

4. 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 thisPolicy.

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.

5. 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 have 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.

6. 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.

Time of Cancellation	Policy Duration (specify for each policy tenure)		
	1 Year	2 Year	3 Year
Up to 1 month	85.00%	92.50%	95.00%
Up to 3 month	70.00%	85.00%	90.00%
Up to 6 month	45.00%	70.00%	80.00%
Up to 12 month	0.00%	45.0%	65.00%
Up to 15 month	N/A	30.00%	55.00%
Up to 18 month	N/A	20.00%	45.00%
Up to 24 month	N/A	0.00%	30.00%

Up to 27 month	N/A	N/A	20.00%
Up to 30 month	N/A	N/A	15.00%
Up to 36 month	N/A	N/A	0.00%

For Policies where premium is paid by installment, the following additional conditions will be applicable:

1. When yearly payment option is chosen, cancellation grid as per 1 Year Tenure policies will be applicable

2. For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable. In case of claim, future instalments for the current policy year will be adjusted in the claim amount.

   In case of admissible claim under the policy, future instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year.

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

7. Premium Payment in Installments

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

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

a. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy

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

c. 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

d. No interest will be charged If the installment premium is not paid on due date

e. In case of installment premium due not received within the Grace Period, the Policy will get cancelled

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

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

8. 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.

9. Renewal of Policy

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

i. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the GracePeriod of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

10. 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

11. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link

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

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. Grievance Redressal Procedure

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

- Website: www.hdfcergo.com
- Toll free: 022 6234 6234 / 0120 6234 6234
- Contact Details for Senior Citizen: 022 – 6242 – 6226 | seniorcitizen@hdfcergo.com
- E-mail: grievance@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**
Contacts 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	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

i. 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.

ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://bimabharosa.irdai.gov.in

II. Specific Terms & clauses

1. Observance of Terms and Conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy insofar as they relate to anything to be done or complied with You shall be a condition precedent to any liability on Us to make any payment under this Policy.

2. Reasonable Care

You shall take all reasonable steps to safeguard against any accident or illnesses that may give rise to any claim under this Policy.

3. Notice of Charge

We shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but Our payment to You or Your nominees or Your legal representative or to the Hospital/ Nursing Home, as the case may be, of any benefit under the Policy shall in all cases be a full, valid and an effectual discharge by Us.

4. Electronic Transactions

You agree to adhere to and comply with all such terms and conditions as We may prescribe from time to time, and hereby agree and confirm that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of this Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from

time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/ confirmed by You.

5. Instalment premium payment through Auto Debit/ ECS Facility

a. If premium payment is opted for by instalments through auto debit/ECS facility, a separate authorization form shall be submitted by Insured Person specifying the frequency chosen for premium to be debited.

b. Where there is a change either in the terms and conditions of the coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh.

c. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable.

d. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode.

1. Place/Currency: No claim shall be payable under this Policy for any treatment or expenses incurred outside India. All claims shall be payable in India and in Indian Rupees only.

6. Income Tax benefit: Premium paid under the Policy shall be eligible for benefits under the Income Tax laws prevailing from time to time.

7. Law Applicable: Laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim thereunder.

8. Claim rejection: If a claim is rejected or partially settled and is not the subject matter of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability extinguished and shall not be recoverable thereafter.

9. Grace Period

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

ii. Policies for which Premium is received after theGrace Period shall be considered as a fresh policy.

10. Medical Underwriting

Proposers above 55 years of age and those having medical history are subject to Medical Underwriting by the Company. We reserve the right to accept such proposals on standard terms/Decline/Accept with exclusion or Premium loading (up to maximum of 100% on basic Premium).These loadings are

applied from Commencement Date of the Policy including subsequent renewal(s) with Us.

11. Endorsements: Following type of endorsement are permissible under the Policy.

1. 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 (if this does not impact the premium)*

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 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

2. 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 shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of Insured person.

F. OTHER TERMS & CONDITIONS

Claims Procedure

It is a condition precedent to Our liability that upon the discovery or happening of any illness/injury that may give rise to a claim under this Policy, You shall:-

1. Claim Notification

Give immediate notice to the Company/TPA named in this Policy/Health Card, by calling the Help Line number as specified in the Policy/Health Card, or in writing to the address shown in the Schedule with particulars as below:

Policy Number,

Name of the person(s) named in the Schedule to this Policyavailing treatment,

Nature of disease/illness/injury,

Name and address of the attending Medical Practitioner/ Hospital

Date of admission & probable date of discharge Approximate Claim Expenses

Any other relevant information

Intimation of claim must be done at least 72 hours prior to Hospitalization in case of planned Hospitalization and within 24 hours of Hospitalization in case of an emergency Hospitalization.

In case where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer.

2. Cashless Facility for Hospitalization

i) We may provide Cashless facility for Hospitalization expenses either directly or through the Third Party Administrator (TPA) if treatment is undergone at a Network Hospital by issue of pre-authorization by Us or the TPA.

ii) For the purpose of considering pre-authorization and Cashless facility, You shall submit to the TPA complete information of the illness or injury requiring treatment along with necessary certification from the Medical Practitioner and/or Hospital.

iii) If claim for treatment appears admissible, We or TPA shall issue pre-authorization to the Hospital concerned for Cashless facility whereby Hospitalization expenses shall be paid directly by Us directly or through the TPA as confirmed in the pre-authorization.

iv) Cashless facility for Hospitalization will not be available for treatment in Non-Network Hospital and may be declined even for treatment at Network Hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such a case, You shall bear the expenses and claim reimbursement, immediately after discharge from Hospital/Nursing Home in accordance with the stipulations herein.

v) Cashless facility for Hospitalization benefit shall be limited exclusively to Hospitalization Expenses incurred for treatment at a Network Hospital for illness or injury which are covered under the Policy and shall be extended only for Coverage mentioned under Scope of cover(A)"Inpatient Hospitalization expenses" and Scope of cover (B) "Day care Procedures"

3. Claims Processing for Reimbursement

i) After intimation as aforesaid, further submit following documents to the TPA at Your own expense within 30 days of discharge from the Hospital, the following:-

- Claim Form Duly filled with requisite information and signed by Insured & Hospital
- Copy of the claim intimation
- Original Hospital Main Bill
- Original Hospital Bill break up (Where issued by the Hospital)
- Original Hospital Bill Payment Receipt
- Hospital Discharge Card/Summary
- Original Pharmacy Bill with supporting prescriptions
- Medical Investigation report: ECG/X-Ray/USG/CT/ MRI/ Histopathology/pathological and all other medical investigation report in support of diagnosisas advised by the treating doctor.
- All Doctor's consultation note: confirming provisional & final diagnosis/advise for admission/medical complication/ proposed line of treatment/past medical history
- Original bills and receipts for claiming Ambulance charges(if any)
- By signing the claim form you are authorizing us to collect the following documents from the Hospital. If you have obtained these documents, then please submit the same
- Operation Theatre Notes in surgical cases
- Bar code sticker & Invoice for implants and prosthesis (if used)
- In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident
- Indoor case papers

Pre and Post hospitalization Claims documents

- Duly filled claim form(s)(If claimed Separately)
- Pharmacy Bills with supporting prescriptions
- Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- All Doctor's consultation note with original bills and receipts for claiming Doctors fees,

ii) Documents pertaining to the Post-Hospitalization claim shall be submitted to the TPA within 15 days from the date of expiry of Post-Hospitalisation coverage period.

iii) At any time You may be required to authorize and permit the TPA and/or Us or anyone deputed by Us or TPA to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.

iv) You should under go medical examination by Medical Practitioner designated by Us or the TPA and the cost of such medical examination will be borne by Us.

We may carry out verification/investigation on a case to case basis to ascertain the facts/collect additional information/ documents of the case to determine the

assessment of loss. Verification carried out, if any, will be done by individuals or entities authorized by Us to carry out such verification/investigation(s) and the costs for such verification/investigation shall be borne by Us.

For determining the amount of admissible claim, applicable taxes prevailing at the time of the claim will be considered as part of claim amount and Our aggregate liability, including any payment towards such Taxes shall in no case exceed the Sum Insured.

4. TPA to Pay or Reject

The TPA where appointed, shall process and communicate rejection, if a claim is found to be not admissible under this Policy as authorized by Us. However all decisions shall be Our responsibility.

5. Representation against Rejection

Where rejection is communicated, You, may if so desired, represent to Us within 15 days for reconsideration of the decision.

6. Condition Precedent

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.

7. Claims Service Assurance

1) If You notify a cashless facility request by sending the pre-authorization form duly filled in and signed through email, fax to Us or Our representative, then within 6 hours of the actual receipt of such a request, We will respond with:

a) Approval, or

b) Rejection.

If such request has been notified during office hours

(9am to 9 pm) on Monday to Saturday and We fail to either approve or reject or seek further information after the expiry of 6 hours from the actual receipt of the request then, We shall be liable to pay You for the delay in the following manner:

i) For delay beyond 6 hours: Rs.1,000/-

ii) The maximum amount that We shall be liable to pay to You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

If such request has been notified after office hours on a working day or at any time during a holiday and We fail to either approve or reject after the expiry of 8 hours from the actual receipt of the request, then We shall be liable to pay You for the delay in the following manner:

iii) For delay beyond 8 hours: Rs.1,000/-

iv) The maximum amount that We shall be liable to pay You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

2) In case of reimbursement claims, We shall communicate

our decision on payment within 6 working days after You submit the complete details, information and document requirements in respect of the claim. If You have provided such information and documents as required by Us and We fail to communicate our decision, then We shall pay You Rs. 1,000/- for a delay beyond 6 days. The maximum amount that We shall be liable to pay You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

3) We will not be liable to make any payments under Clauses 1 and 2 above in case of any natural event or manmade disturbance which impedes Our ability to make a decision or to communicate such decision to You.

4) Any amounts paid under this Clause will not affect the Sum Insured as specified in the Schedule. Our liability to make payments under this Clause shall at all times be restricted to the amounts specified in Clause 1 and 2 above including the maximum amount specified therein and You shall not be entitled to any sum whatsoever, in excess of those amounts. Any payment made under this Clause by Us will not amount to any admission of liability for a claim notified by You. Service Assurance is applicable only to the first response on a single claim and to no subsequent correspondence.

The above compensation shall be paid to You notwithstanding Our obligation to pay interestat a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by the Company in cases of delay in settlement of claims, as per Reg. 9(6) of IRDA (Protection of PolicyHolder's Interests) Regulations 2002.

8. Claim Settlement (Provision for Penal Interest)

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 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 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 and at Ourcost, 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

Contact Us

	Within India	**Outside India**
	Toll Free :022 6234 6234 / 0120 6234 6234 Email:healthclaims@hdfcergo.com	Toll Free No: 800 08250825 Global Toll Free No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email: healthclaims@hdfcergo.com
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	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, AndheriKurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

List of Ombudsman

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - 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.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh
GUWAHATI 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.
HYDERABAD 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 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II,Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad 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 Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

23. IRDA REGULATIONS: This Policy is subject to Regulations of IRDA (Protection of Policyholder's Interests) Regulations, 2002 as amended from time to time.

Annexure I - List of Non-Medical Expenses

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

S. No.	Item
30	Medical certificate
31	Medical records
32	Photocopies charges
33	Mortuary charges
34	Walking aids charges
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

List II–Items that are to be subsumed into Room Charges

S. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES

S. No.	Item
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III–Items that are to be subsumed into Procedure Charges

S. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV–Items that are to be subsumed into costs of treatment

S. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG