HDFC ERGO General Insurance Company Limited

Policy Wordings

iCanEnhance

CONTENTS

PREAMBLE

HDFC ERGO General Insurance Limited will cover all Insured Person(s) under this Policy subject to the terms, conditions & exclusions under the policy.

IMPORTANT NOTES -

i) This policy offers coverage ONLY for Cancer, provided it occurs for the first time during the Policy Period.

ii) The Sum Insured applicable for each benefit has been mentioned in the Schedule of Benefit (refer annexure I).

iii) Refer to section A of the Policy Wordings for the definitions (wherever applicable) to understand the benefits.

SECTION A: DEFINITIONS

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

I. Standard Definitions

Def. 1. **Accident** means sudden, unforeseen, and involuntary event caused by external, visible or violet means.

Def. 2.**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.A**YUSH 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. **Cancer of specified severity** (Applicable to Section B.C.& B.D. of this Policy)

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0

(TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

Def. 6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 7. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position

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

b) External Congenital Anomaly- which is in the visible and accessible parts of the body

Def. 8. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup

with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i) has qualified nursing staff under its employment;

ii) has qualified medical practitioner/s in charge;

iii) has fully equipped operation theatre of its own where surgical procedures are carried out;

iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 9. **Day care Treatment** means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

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

Def. 11. **Emergency Care** means management for 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. 12. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

Def. 13. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock,
- 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 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 make these accessible to the insurance company's authorized personnel.

Def. 14. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum of 24 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. 15. **Illnessmeans a sickness** or **a disease** or **pathological** condition leading to the impairment of normal physiological function and requires medical treatment

a) **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

b) **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics:

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

Def. 16. **Injury** means accidentalphysicalbodily 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. 17. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24

hours for a covered event.

Def. 18. **Inpatient Treatment** Expenses means the medical expenses incurred on Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.

Def. 19. **Incentive 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. 20. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 21. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

Def. 22. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 23. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Def. 24. **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. 25. **Network Provider** means Hospitals enlisted by an insurer, TPA or jointly by Insurer and TPA to provide medical services to an insured by a cashless facility

Def. 26. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network

Def. 27. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any recognized modes of communication.

Def. 28. **Outpatient Treatment** means the treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 29. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Def. 30. **Pre-existing Condition** 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. 31. Pre- Hospitalisation Medical Expenses means the Medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided that:

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

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

Def. 32. **Post- Hospitalisation Medical Expenses** means Medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

iii. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and

iv. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

Def. 33. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 34. **Reasonable** & **Customary Charges** means the charges for services or supplies, which are the standard

charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 35. **Room Rent** means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

Def. 36. **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. 37. **Surgery** or **Surgical Procedure** means manual and/or operative procedure 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 medical practitioner

Def. 38. **Unproven / Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

II. Specific Definition

Def. 1. Advanced Metastatic Cancer means the diagnosis of Stage IV (based on TNM classification) or advanced metastatic cancer, evidenced by spread of cancer to other organs or parts of the body which are not directly connected with each other basis confirmation by histopathological evidence &/or radiological evidence like PET, CT, MRI.

Spread of cancer to lymph nodes only is not covered under this definition.

Def. 2. **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 3. Bank Rate shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 4. Cancer (Applicable to Section B.B. of this Policy)

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

ii) Please note the following is Included -

- Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.
- Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia.

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 is approved.

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

Def. 7. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def. 8. **Date of Diagnosis** refersto the date of histopathology report,basiswhichMedicalPractitionerconfirms the initial diagnosis of Cancer.

Def.9. **Insured Person** means You and the persons named in the Policy Schedule.

Def. 10. **Material facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk

Def. 11. **Policy** means and includes Your statements in the proposal form (which are the basis for this Policy), this fever Care Policy wording (including endorsements, if any), Annexure 1 and the Policy Schedule (as may be amended from time to time).

Def. 12. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule.

Def. 13. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 14. **Recurrence of Cancer** is defined as the return of cancer of specified severity with same cellular morphology (as diagnosed earlier) at the same site or elsewhere, after treatment completion evidenced by histopathological confirmation of no remaining cancer cells and after a period of continuous follow up during following 24 months when cancer was not detected.

Def. 15. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Def. 16. **Shared accommodation** means a Hospital room with two or more patient beds.

Def. 17. **TPA** means the third party administrator that We appoint from time to time as specified in the Policy Schedule.

Def. 18. **We/Our/Us** means the HDFC ERGO General Insurance company Ltd.

Def. 19. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

SECTION B: BENEFITS COVERED IN THE POLICY

A. Second Opinion

The Insured can request for a second opinion, on first diagnosis of Cancer. It will be provided through our panel of medical practitioners who may access artificial intelligence, deep analytics & cognitive software.

The opinion will be directly sent to the insured person by the medical practitioner. This benefit can be availed once on first

occurrence of Cancer.

B. MyCare Benefit

Eligible Medical Expenses towards treatment of Cancer are covered.

Please Note, this benefit is applicable for Cancer as defined in Specific Definitions, Def. 3 in section A of this policy

iCan offers two plan options, as per plan option selected & displayed on Policy Schedule following

expenses are covered. Refer Schedule of Benefits (Annexure I) for details

Standard Plan	Advanced Plan
Treatments for Cancer availed in IN-PATIENT or OUT-PATIENT or DAYCAREare covered. **i. Conventional treatments** Following treatments are covered - • Chemotherapy • Radiotherapy • Organ transplantation, as part of Cancer treatment • Surgeries for excision of cancerous tissue or removal of organs/ tissues (Onco-surgery) Note pertaining specifically to AYUSH Treatments only: Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.	In addition to coverage under standard plan, following **Advanced treatments** are also covered - • Proton beam therapy • Immunotherapy including immunology agents • Personalised & Targeted therapy • Hormonal Therapy or Endocrine manipulation • Stem cell transplantation
ii. Pre- hospitalization Medical expenses incurred in the 30 days immediately before the date of admission in the Hospital.	
iii. Post- hospitalization Medical expenses incurred during 60 days immediately after insured person is discharged from the Hospital.	
iv. Emergency Ambulance – Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to the limit as per schedule of benefits.	
v. Follow Up care Post treatment - • Expenses incurred on medical examination twice a year, provided treatment for Cancer has been discontinued basis recommendation of Medical Practitioner for atleast six months with "No evidence of disease (NED)".	

IMPORTANT TERMS TO KNOW

Inpatient Treatment means the treatment for Cancer where Insured Person has to stay in a Hospital for more than 24 hours.

Date of Diagnosis refersto the date of histopathology report,basis whichMedical Practitioner confirms the initial diagnosis of Cancer.

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

Outpatient (OPD) Treatment means the treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Day care Treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs. because of technological advancement, &

ii. 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.

C. CritiCare Benefit

Please Note –

a. This benefit is applicable for "Cancer of Specified Severity", any referenceof "Cancer"in this section refers to Cancer of Specified Severity (Refer Standard Definitions Def. 3 in section A of this policy)

b. Eligible claim amount under this benefit is over and above the "MyCare"Sum insured& is payable only ONCE under the policy, including renewals.

c. CritiCare Benefit is applicable for ONLY those Insured Person(s) who are 18 years and above on Policy Commencement Date.

On first diagnosis of Cancer of specified severity during the policy period, We will pay the Insured person

Lumpsumamount equivalent to 60% of the Sum Insured.

Conditions applicable-

- If the first diagnosis of Cancer is identified as Advanced Metastatic Cancer, the Insured person will be eligible for FamilyCare Benefit &NO payment shall be made under CritiCare benefit.

D. FamilyCare Benefit

Please Note-

a) We will pay a lumpsum benefit amount equivalent to 100% of the Sum Insured towards this benefit on occurrence of either of the below (whichever is earlier) during the policy period,

i) Advanced metastatic Cancer (Stage IV) OR

ii) Recurrence of Cancer

b) Sum Insured under this benefit is Over and above "MyCare"Sum insured & is payable only ONCE under this policy (including renewals).

c) FamilyCare Benefit is applicable for ONLY those Insured Persons who are 18 years and above on

Policy Commencement Date.

Conditions applicable-

- If the cancer is diagnosed as Advanced Metastatic Cancer within 12 months after the first diagnosis of Cancer of specified severity as stated under CritiCare benefit and We have made payment under CritiCare benefit, then the amount paid under CritiCare benefit shall be subtracted from FamilyCare benefit payout
- If the first diagnosis of Cancer is identified as Advanced Metastatic Cancer, the Insured person will beeligible for FamilyCare Benefit & NO payment shall be made under Criticare benefit.

IMPORTANT TERMS TO KNOW

Commencement Date means the commencement date of this Policy as specified in the Policy Schedule. On renewal, it considered as commencement date of Renewal policy.

Recurrence of Cancer is defined as the return of cancer of specified severity with same cellular morphology (as diagnosed earlier) at the same site or elsewhere, after treatment completion evidenced by histopathological confirmation of no remaining cancer cells and after a period of continuous follow up during following 24 months when cancer was not detected.

Advanced Metastatic Cancer means the diagnosis of Stage IV (based on TNM classification) or advanced metastatic cancer, evidenced by spread of cancer to other organs or parts of the body which are not directly connected with each other basis confirmation by histopathological evidence &/or radiological evidence like PET, CT, MRI.

Spread of cancer to lymph nodes only is not covered under this definition.

SECTION C: WAITING PERIOD & EXCLUSIONS

I. Specific Waiting Period

- 120 days waiting period shall apply from commencement date of the policy to all claims in the policyprovided the customer has been continuously covered without any break.

II. Standard General exclusions

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

i) Any Illness or Accident other than for Cancer.

ii) 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.

iii) 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.

iv) 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

v) Investigation and evaluation: Code – Excl04

- Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

vi) 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:

- 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.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

vii) Preventive care

viii) Any external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).

ix) 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.

x) Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure.Code – Excl14

III. Specific Exclusions

i) Non-Allopathic treatments except In-patient care AYUSH treatments taken in an AYUSH Hospital

ii) Prosthetic and devices which are self-detachable / removable without surgery involving anaesthesia. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com. Treatment availed outside India or at a healthcare facility which is NOT a Hospital

iii) Congenital external diseases, defects or anomalies

iv) Specified healthcare providers (Hospitals /Medical Practitioners)

- Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he islicensed.
- Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.
- Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by treating doctors prescription.

v) Treatment for alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12

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

vii) Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature

SECTION D: GENERAL CONDITIONS

I. Standard General Conditions

a. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

The premium for the policy will remain the same for the policy period as mentioned in policy schedule. Policy will be issued for one year and the Sum Insured & benefits will be applicable on Policy Year basis.

b. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

c. Provision for Penal Interest

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

b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

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

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.

d. 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.

e. 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.

f. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

g. Renewal of Policy

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

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

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

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

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

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

h. 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.

i. 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.

j. Cancellation

i) The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

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

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

k. 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;

l. Moratorium Period

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

m. 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

n. 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://igms.irda.gov.in/

II. Specific General Conditions

a. Geography

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

b. Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian laws.

c. Insured Person

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

Addition of eligible members is allowed at renewal subject to the application being accepted by us and the premium received. Spouse can also be added during the policy period after the application has been accepted by Us and additional premium has been received and We have issued an endorsement confirming the addition of such person as an Insured Person.

d. Loadings & Discounts

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

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7 days, we shall cancel your application and refund the premium paid within next 7 days.Please note that We will issue Policy only after getting Your consent.

e. Notification of Treatment

We must be informed of any event or occurrence that may give rise to a claim under this Policy –

i. Within 7 days of completion of treatment, consultation or procedure, and/ or

iii. Within 14 days of Date of Diagnosis of first occurrence of Cancer of specified severity and/ or

iv. Within 14 days of Date of Diagnosis of Advanced metastatic cancer OR Recurrence of Cancer.

Duly signed claim form and all the information/ documents mentioned should be submitted within 15 days of the occurrence of the Incident.

For Cashless Service (In case of Cancer Therapies) :

	Treatment, Consultation or Procedure:	**Treatment, Consultation or Procedure Taken at:**	**Cashless Service is Available:**	**We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:**
i.	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation
ii.	If any treatment, consultation or procedure for which a claim may be made to be taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

f. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf has to provide Us with the list of documentation, medical records and information mentioned below within 15 days of the event as mentioned above. We may request for medical records, documentation and information to establish the circumstances, its quantum or Our liability for the claim. We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured.

List of documentation as referred above will include but is not limited to the following:

i) Our claim form duly completed and signed for on behalf of the Insured Person.

ii) Original bills with detailed breakup of charges (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

iii) Original payment receipts

iv) All original reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.

v) Original Discharge Summary containing details of Date of admission and discharge detailed clinical history, detailed past history, procedure details and details of treatment taken

vi) Medical certificate confirming the diagnosis/treatment of Cancer from Medical Practitioner.

vii) A precise diagnosis of the treatment for which a claim is made.

viii) A detailed list of the individual medical services and treatments provided and a unit price for each.

ix) Original Prescriptions that name the Insured Person andin the case of drugs: the drugs prescribed, their price and a receipt for payment.Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.

x) Indoor case papers on case to case basis if required.

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

h. Claims Payment

ii) We will be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

iii) We will only make payment to You under this Policy. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Policy Schedule). The assignment of benefits payable under this Policy shall be subject to applicable law.

i. 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:

b. cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule ; and

c. 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 i above.

j. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

k. Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of

the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

I. Notices

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i) Any Insured Person, it would be sent to You at the address specified in Policy Schedule / endorsement

ii) Us,shall be delivered to Our address specified in the Policy Schedule.

iii) No insurance agents, brokers or other person/ entity is authorised to receive any notice on Our behalf.

SECTION E: OTHERS

I. 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

II. Claim Related Information

	Within India	Outside India
Claim Intimation:	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, Andheri Kurla Road, Andheri East, Mumbai - 4000 59, 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.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
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.
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

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
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.
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.

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

Annexure I - List of Non-Medical Expenses

Sr. 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
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

Schedule of Benefits

Sum Insured (as opted and displayed on Policy Schedule) - INR 5,00,000; 10,00,000; 1500,000; 2000000; 2500000; 5000000	
A. Second Opinion	**Included**
B. MYCAREBenefit **i. Conventional/ Advanced Treatment** **ii. Pre-Hospitalisation - 30 days** **iii. Post Hospitalisation – 60 days**	**Upto Sum Insured**
iv. Emergency Ambulance	INR 2000 per hospitalization
v. Follow up care post treatment	Upto INR 3000 twice a year
C. CRITICAREBENEFIT	Lumpsum payment equivalent to 60% of sum insured
D. FAMILYCARE BENEFIT	Lumpsum payment equivalent to 100% of sum insured