

HDFC Group Health Insurance - Prospectus

Key features of the policy:

1. Entry age limit of 65 years with lifetime renewal
2. Various optional covers available such as Hospital Cash, Cumulative Bonus etc.
3. 100% Sum Insured Restore Benefit available.
4. PED coverage after 48 months.
5. Option to pay premium in monthly, quarterly and half-yearly installments

SECTION A. GOLD PLAN

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

1. In-Patient Hospitalization

- i. Room Rent and boarding charges up to 1% of Base Sum Insured, subject to a maximum limit of INR 3000 per day
- ii. Intensive Care Unit charges up to 2% of Base Sum Insured
- iii. Consultation fees & Nursing charges
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
- v. Medicines, drugs and consumables
- vi. Diagnostic procedures
- vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

a. Special Conditions

i. Room Rent & Proportionate deduction:

In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/payment of Room Rent charges including all Associated Medical Expenses incurred at Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. This condition is not applicable in respect of Hospitals where differential billing for Associated Medical Expenses is not followed based on Room category.

ii. Mental Illness

The Coverage for Mental illness is applicable if done in Mental Health Establishment and is subject to the provisions contained in the Mental Health Care Act, 2017, as amended from time to time and other applicable laws and Regulations.

2. Pre-Hospitalization Medical Expenses Cover

We will pay for the Pre-Hospitalization Medical Expenses incurred during the 60 days immediately before Hospitalization of an Insured Person.

3. Post-Hospitalization Medical Expenses Cover

We will pay for the Post-Hospitalization Medical Expenses incurred upto 90 days from the date Insured Person is discharged from Hospital.

4. Day Care Procedures

We will pay for the Medical Expenses under Section A1 on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment.

5. Domiciliary Hospitalization

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

6. Road Ambulance Cover

For each admissible Claim under Section A1 and A4, We will pay for expenses incurred on Road Ambulance Services if Insured Person is required;

- i. to be transferred to the nearest Hospital following an emergency

(namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)

- ii. or from one Hospital to another Hospital
- iii. or from Hospital to Home (within same City) following Hospitalization

7. Organ Donor Expenses

We will pay Medical Expenses covered under Section A1 towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient subject to condition that;

- i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/ or Regulations.
- ii. Hospitalization Claim under Section A1 is admissible under the coverage for the Insured Person
- iii. The Organ Donor's Pre-Hospitalization and Post-Hospitalization Medical Expenses are excluded under the Policy.
- iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy.

SECTION B. PLATINUM PLAN

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

1. In-Patient Hospitalization

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

a. Special Conditions

i. Mental Illness

The Coverage for Mental illness is applicable if done in Mental Health Establishment and is subject to the provisions contained in the Mental Health Care Act, 2017, as amended from time to time and other applicable laws and Regulations.

2. Pre-Hospitalization Medical Expenses cover

We will pay for the Pre-Hospitalization Medical Expenses incurred during the 60 days immediately before Hospitalization of an Insured Person.

3. Post-Hospitalization Medical Expenses cover

We will pay for the Post- Hospitalization Medical Expenses incurred upto 180 days from the date Insured Person is discharged from Hospital.

4. Day Care Procedures

We will pay for the Medical Expenses under Section B1 on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment.

5. Domiciliary Hospitalization

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

6. Road Ambulance Cover

For each admissible Claim under Section B1 and B4, We will pay for

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expenses incurred on Road Ambulance Services if Insured Person is required;

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

7. Organ Donor Expenses

We will pay Medical Expenses covered under Section B1 towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient subject to condition that;

- i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/ or Regulations.
- ii. Hospitalization Claim under Section B1 is admissible under the coverage for the Insured Person
- iii. The Organ Donor's Pre-Hospitalization and Post-Hospitalization Medical Expenses are excluded under the Policy.
- iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy.

- ii. Cumulative Bonus will be reduced at the same rate as accrued in the event of admissible Claim under the Coverage.
- iii. Cumulative Bonus can be accumulated upto the limit mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.
- iv. Cumulative Bonus applied will be applicable only to Insured Person(s) covered under the expiring Coverage and who continue to remain insured on Renewal.

3. Hospital Cash

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

- i. Hospitalization
- ii. Domiciliary Hospitalization
- iii. Hospitalization for Alternative Treatments of an Insured Person within India, We will pay per day Sum Insured as specified on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance subject to maximum number of benefit days for each continuous and completed period of 24 hours of such Hospitalization.

4. Restore Benefit

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

Conditions for Restore benefit:

- a. The Sum Insured will be restored only once in a Policy Year.
- b. If the Restored Sum Insured is not utilized in a Policy Year, it will expire.
In case of a Family Floater Policy, Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

5. Waiting period Modification Option

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

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

6. Specific Illness Waiting period Modification Option

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

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

7. Alternative Treatment

— We will pay **Medical Expenses** covered under Section A or B as opted, only on **Medically Necessary In-patient care treatment of Insured Person in Ayush Hospital** upto the limit mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance for following **Alternative Treatments** prescribed by **Medical Practitioner**:

- Ayurvedic
- Unani
- Siddha
- Homeopathy
- Yoga & Naturopathy

Note : Alternative Treatment is no longer an optional cover. Basis CIR. Ref. IRDAI/HLT/CIR/GDL/31/01/2024 issued by IRDAI, all Insured Persons shall be covered by default for In-patient care expenses under this cover upto Sum Insured of Gold Plan or Platinum Plan as opted.

Details mentioned in the Policy Schedule against this cover shall be superseded by the above wordings.

SECTION C. OPTIONAL COVER

Insuring Clause

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

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

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

1. Preventive Health Check Up

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

Other terms and Conditions applicable to this Coverage

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

2. Cumulative Bonus

On each continuous Renewal of the Coverage with Us, We will apply 10% of Base Sum Insured under expiring Cover as Cumulative Bonus in the Coverage provided that;

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

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SECTION D. WHAT IS NOT COVERED

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

I. Waiting Periods

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

i) Pre-existing Diseases – Code – Excl01

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

ii) Specified Disease/Procedure waiting period - Code - Excl02

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

Illnesses

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

Surgical Procedures

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

iii) 30-day waiting period – Code – Excl03

- a) Expenses related to the treatment of any Illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
- c) The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

II. Permanent Exclusions

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

i. Investigation & Evaluation: Code - Excl04

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

ii. Rest Cure, rehabilitation and respite care: Code – Excl05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. Obesity/Weight control: Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- a. Surgery to be conducted is upon the advice of the doctor
- b. The surgery/procedure conducted should be supported by clinical protocols
- c. The member has to be 18 years of age or older and
- d. Body Mass Index (BMI)
 - 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:

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- iii. Obesity related cardiomyopathy
 - iv. coronary heart disease
 - v. severe sleep apnoea
 - vi. uncontrolled type2 diabetes
- iv. **Change-of-Gender treatments:** Code – Excl07: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
 - v. **Cosmetic or plastic surgery:** Code – Excl08: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
 - vi. **Hazardous or Adventure Sports:** Code – Excl09– Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.
 - vii. **Breach of Law:** Code – Excl10 - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
 - viii. **Excluded Providers:** Code – Excl11- Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.
 - ix. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12
 - x. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code – Excl13
 - xi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. Code – Excl14
 - xii. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries. Code – Excl15
 - 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:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c. Gestational Surrogacy
 - d. Reversal of sterilization
 - xv. **Maternity:** Code – Excl18
 - a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.
 - xvi. War or any act of war (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, Chemical or Biological attack or weapons, radiation of any kind.
 - xvii. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
 - xviii. Any Insured Person's participation or involvement in naval, military or air force operation.
 - xix. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
 - xx. Congenital external diseases, defects or anomalies,
 - xxi. Stem cell harvesting.
 - xxii. Investigative treatments 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).
 - xxiii. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
 - xxiv. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
 - xxv. 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.
 - xxvi. Vaccination including inoculation and immunisations (Except post Animal bite treatment),
 - xxvii. 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 available at www.hdfcergo.com.
 - xxviii. Treatment taken on Outpatient basis.
 - xxix. The provision or fitting of hearing aids, spectacles or contact lenses.
 - xxx. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, Optometric therapy.
 - xxxi. 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.
 - xxxii. Expenses for Artificial limbs or and/or device used for diagnosis or treatment (except when used intra-operatively), prosthesis, corrective devices, external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses also available on www.hdfcergo.com.
 - xxxiii. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

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SECTION E. CLAIMS PROCEDURE

1. Notification of a Claim

Procedure	Cashless Hospitalization		Reimbursement Claims
	Emergencies	Planned	
Claim Intimation You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website			
Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for claim notification	i. The health card issued by Us ii. KYC documents iii. The Policy Number iv. Name of the Policyholder v. Name and address of Insured Person vi. Nature of the Illness/Injury and the treatment required vii. Name and address of the attending Medical Practitioner viii. Name of Hospital for admission/treatment ix. Proposed /Actual Date of admission x. MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury).		
Hospital Cash	i. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge ii. First consultation letter from treating Medical Practitioner iii. Certificate from treating Medical Practitioner, specifying the duration and aetiology iv. MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury). v. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), vi. legal heir certificate in case nominee is minor.		
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the Insured person(s) iii. Nature of disease/Illness/Injury iv. Name and address of the attending Medical Practitioner / Hospital v. Date of admission & probable date of discharge vi. Approximate Claim Expenses		Not Applicable
	Any other relevant information as required		Not Applicable
Process for pre-authorization	On receipt of duly filled pre authorization form and other details, We may; • Issue the authorization letter specifying the sanctioned amount, limitation, and non-payable items, if applicable Or • Reject the request for pre-authorization specifying reasons for the rejection.		Not Applicable
List of Claim documents	Not Applicable		As enlisted below
Condonation of Delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control		

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2. List of documents for Reimbursement Claims

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

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

3. Conditions for obtaining Cashless facility

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

We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim

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

SECTION F. GENERAL CONDITIONS

1. Entry Age:

Base Cover:

Proposer	Adult Dependent	Child/Children
• Minimum Entry Age – 18 Years	• Minimum Entry Age – 18 Years	• Minimum Entry Age – 91 days
• Maximum Entry Age – 65 Years	• Maximum Entry Age - 65 Years	• Maximum Entry Age - 25 years

Optional covers:

Proposer	Adult Dependent	Child/Children
• Minimum Entry Age – 18 Years	• Minimum Entry Age – 18 Years	• Minimum Entry Age – 91 days
• Maximum Entry Age – 65 Years	• Maximum Entry Age - 65 Years	• Maximum Entry Age - 25 years

2. Type of Policy:

Individual and Family Floater

3. Coverage for dependents:

- Floater Sum Insured Option: Self, Spouse, Dependent Children* and Dependent Parents.
- Dependent children: A child is considered a dependent for insurance purposes until his 25th birthday (even if not enrolled in an educational institution) provided he is financially dependent, on the proposer.

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4. Policy period

This policy can be issued for 1 year

5. Sum Insured Options

- 1 lac
- 2 lacs
- 3 lacs
- 4 lacs
- 5 lacs
- 7.5 lacs
- 10 lacs
- 15 lacs
- 20 lacs
- 25 lacs
- 50 lacs

6. Sum Insured for Optional Covers

Preventive Health Check Up	1% of Base Sum Insured, max upto INR 2000 during block of 3 years		
	1% of Base Sum Insured, max upto INR 7500 for every claim free year		
Cumulative Bonus	10% max up to 50%	10% max up to 100%	
Hospital Cash	Per day Sum Insured in ₹	500	1000
Restore Benefit	100% of Basic Sum Insured		
Waiting Period Modification Option	3 years	2 years	1 year
Specific Illness Waiting Period	1 Year		
Alternative Treatment	10% of Base Sum Insured		
	25% of Base Sum Insured		
	50% of Base Sum Insured		
	100% of Base Sum Insured		

7. Pre-Policy Check Up

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

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

- Set 1:** ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG
- Set 2:** ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG, HBsAg, TMT/2D Echo, USG Abdomen & Pelvis, Chest X ray, CEA
- Set 3:** Set 2, PSA (Males), Pap Smear & Sonomamography (Females), Micro albumin, BUN, Sr Uric Acid, ANA

Guidelines for Pre Policy Check up

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

8. Non - Disclosure or Misrepresentation

- i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the Proposal Form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:
 - a) cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us at Our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Policy Schedule/ Certificate of Insurance, and
 - b) the claim under such Policy if any, shall be prejudiced.
- ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/ Misrepresentation of Pre-existing Diseases subject to your prior consent;
 - a) Permanently exclude the disease/condition and continue with the Policy
 - b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
 - c) Levy underwriting loading from the first year of issuance of Policy or renewal, whichever is later.

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

9. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non- disclosure of any Material Fact by the Policyholder.

10. Condition Precedent to Admission of Liability

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

11. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

12. Multiple Policies

- i. In case of multiple policies taken by an 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

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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.

13. Moratorium Period

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

14. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/ policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance Policy:

- a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of Material fact are within the knowledge of the Insurer.

15. Geography

This Policy only covers Medical Treatment taken within India.

16. Loadings

- i. We may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.
- ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each Insured Person
- iii. Loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum

Insured. We will not apply any additional loading on YourPolicy premium at Renewal based on claim experience in YourPolicy.

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

17. Renewal of Policy

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

18. Grace Period

- i. A Grace Period of 30 days is available for Renewal of the Coverage. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.
- ii. For Renewal received after completion of Grace Period, the Coverage would be considered as fresh without any Renewal benefits
- iii. For Policies on instalment basis, Grace Period is available as given below.

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

19. Free look period

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

The Insured Person shall be allowed Free Look period of fifteen days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

20. Migration

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

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

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21. Portability

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

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

22. Endorsements

The following endorsements are permissible during the Policy Period: Non-Financial Endorsements – which do not affect the premium

- i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
- ii. Rectification in gender of the Insured Person
- iii. Rectification in relationship of the Insured Person with the Proposer
- iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)
- v. Change in the correspondence address of the Insured Person/ Proposer(if this does not impact the premium)
- vi. Change in Nominee Details
- vii. Change in Height, weight, marital status (if this does not impact the premium)
- viii. Change in bank details
- ix. Any other non-financial endorsement

Financial Endorsements – which result in alteration in premium

- i. Change in Age/date of birth
- ii. Change in Height, weight
- iii. Addition of Insured Person (New Born Baby or newly wedded spouse)
- iv. Deletion of Insured Person on death or Marital separation
- v. Any other financial endorsement

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

23. Cancellation

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

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

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has

been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

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

24. Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy

Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

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

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

- ii. During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
- iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.
- iv. No interest will be charged If the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
- vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.
- vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

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

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

26. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of Renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the Policy has been maintained without a break.

27. Nomination

The Policyholderis required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee (as named in the PolicySchedule/PolicyCertificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholderwhose discharge shall be treated as full and final discharge of its liability under the Policy.

28. Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall

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be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the Bank Rate.

- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the Bank Rate from the date of receipt of last necessary document to the date of payment of claim.

29. Disclaimer applicable to HDFC ERGO Mobile App and associated services

It is agreed and understood that Our HDFC ERGO Mobile App intention is not to provide specific medical advice but rather to provide users with information to better understand their health and their diagnosed disorders. The information is not a substitute for professional medical care by a qualified doctor or other health care professional.

The information provided is general in nature and is not specific to you. You must never rely on any information obtained using this app for any medical diagnosis or recommendation for medical treatment or as an alternative to medical advice from your physician or other professional healthcare provider. If you think you may be suffering from any medical condition you should seek immediate medical attention.

Reliance on any information on this App is solely at your own risk. HDFC ERGO General Insurance Company Limited do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations, any decision made or action taken or not taken in reliance upon the information.

30. Communication & Notice

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

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

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees.

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

Annexure I – Plan Chart

Base Hospitalisation Cover	Group Health Product	
	Gold Plan	Platinum Plan
In-Patient Hospitalisation	Covered Up-to Sum Insured	Covered Up-to Sum Insured
Room Rent Limit (Per Day)	1% of Base SI, max 3,000	At Actuals
ICU Limit (Per Day)	2% of Base SI	At Actuals
Pre Hospitalisation (Days)	60	60
Post Hospitalisation (Days)	90	180
Day Care Procedures	All Day Care Treatments covered	All Day Care Treatments covered
Domiciliary Treatment	Covered Up-to Sum Insured	Covered Up-to Sum Insured
Organ Donor Expenses	Covered Up-to Sum Insured	Covered Up-to Sum Insured
Ambulance Cover	Upto 2,000/hospitalisation	Upto 2,000/hospitalisation

Optional Covers			
Preventive Health Check Up	1% of Base Sum Insured, max upto INR 2000 during block of 3 years		
	1% of Base Sum Insured, max upto INR 7500 for every claim free year		
Cumulative Bonus	10% max up to 50%	10% max up to 100%	
Hospital Cash	Per day Sum Insured in ₹	500	1000
		Up to maximum number of 30 days	
Restore Benefit	100% of Basic Sum Insured		
Waiting Period Modification Option	3 years	*2 years	*1 year
	Specific Illness Waiting Period*		
Alternative Treatment	10% of Base Sum Insured		
	25% of Base Sum Insured		
	50% of Base Sum Insured		
	100% of Base Sum Insured		

*Only applicable for Sum Insured greater than INR 4 lacs