HDFC ERGO Group Health Insurance

Policy Wordings (PWs)

TABLE OF CONTENTS

Sr. No.	Particulars	Page No.
1	Preface	2
2	Standard Definitions	3
3	Specific Definitions	8
4	Base Indemnity Coverage	18
5	Optional Coverages	20
6	Other Base Coverages	50
7	Waiting Period	67
8	Standard Permanent Exclusions	69
9	Specific Permanent Exclusions	71
10	Standard General Terms and Clauses	72
11	Specific Terms and Clauses	78
12	Other Terms and Conditions	82
13	Ombudsman Details	86
14	Annexures	89

SECTION 1 - PREFACE

A. OPERATING CLAUSE

We will provide Insurance coverage to the **Insured Person**(s) under this **Policy** up to **Sum Insured** as applicable for the specific cover. Coverage under this Policy is subject to exclusions, waiting periods, limits, Sub-limits, **Co-payment**, **Deductible**, **Aggregate Deductible** as specified in the **Policy Schedule**/Certificate of Insurance.The **Policy** is based on statements, disclosures, declarations made in the Proposal form/Enrollment form and Medical reports.

B. DEFINITIONS

The terms defined below have the meanings as described 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** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. **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. 3. **AYUSH HOSPITAL** means an AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner*(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:
    i. Having at least 5 in-patient beds;
    ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center 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. 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. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon

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

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

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

Def. 8. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A **Co-Payment** does not reduce the Sum Insured

Def. 9. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 10. **Day care Centre** means any institution established for Day Care Treatment of Illness and / or injuries or a medical set -up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-

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. 11. **Day Care Treatment/ Procedures** means those medicaltreatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours 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. 12. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 13. **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. 14. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury whichin the normal course would require care and treatment at a Hospital but is actually takenwhile confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a Hospital

Def. 15. **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. 16. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital cash policies, which will apply before any benefits are payable by the insurer. A Deductible does not reduce the sum insured.

Def. 17. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def. 18. **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:

i. 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,
ii. has qualified nursing staff under its employment round the clock,
iii. has qualified Medical Practitioner(s) in charge round the clock,
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out,
v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 19. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 20. **Illness/Illnesses**means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

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

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

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

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

Def. 22. **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. 23. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 24. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 25. **Maternity Expenses** means

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during Hospitalization).
b. Expenses towards lawful medical termination of pregnancy during the policy Period.

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

Def. 27. **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 Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 28. **Medically Necessary treatment** means any treatment, test, medication, or stay in **Hospital** or part of stay in **Hospital** which

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

Def. 29. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 30. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 31. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 32. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

Def. 33. **Non Network** means any Hospital, Day Care Centre or other provider that is not part of the Network

Def. 34. **Non-Medical Expenses –** Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergohealth.com

Def. 35. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 36. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer

Def. 37. **Pre-existing disease** means any condition, ailment, injury or disease:

i. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
ii. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def. 38. **Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 39. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and
ii. The in-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

Def. 40. **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. 41. **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. 42. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the AssociatedMedical Expenses

Def. 43. **Reasonable and 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. 44. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

Def. 45. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a medical practitioner.

II. SPECIFIC DEFINITIONS

Def. 1. **Adventurous/Hazardous Sports means** any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

Def. 2. **Age** or **Aged** means completed years as at the Policy Commencement Date.

Def. 3. **Alternative treatment** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha, Homeopathy, Yoga & Naturopathy in the Indian context.

Def. 4. **Aggregate Deductible:** Aggregate deductible is a cost-sharing requirement under a health insurance policy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. An Aggregate deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalization expenses incurred which are admissible under this Policy (and not excluded) during the policy year by insured person (individual Sum Insured policy) or insured family (in case of floater sum insured policy).

Def. 5. **Associated Medical Expenses** means medical expenses such as Professional fees, OT charges, Procedure charges, etc., which vary based on the room category occupied by the insured person whilst undergoing treatment in some of the hospitals. If Policy Holder chooses a higher room category above the eligibility defined in policy, then proportionate deduction will apply on the Associated Medical Expenses in addition to the difference in room rent. Such associated medical expenses do not include Cost of pharmacy and consumables, Cost of implants and medical devices and Cost of diagnostics.
Proportionate deduction shall not be applicable to 'ICU charges' also.

Def. 6. **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

Def. 7. **Bank rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 8. **Base Sum Insured** means the limit opted at the time of inception or modified at the time of renewal whichever is later, for a particular coverage / section of the Policy. It forms a part of the Company's liability with regards to the cover in a given Policy Year. In case of Individual Policies Base Sum Insured shall be on per Insured Person basis. In case of Family Floater policies, a common Base Sum Insured shall be available on a floating basis amongst all the Insured Persons. Base Sum Insured for a coverage / section shall be on a Policy Year basis unless specified otherwise in the benefit or mentioned in the Policy Schedule / Certificate of Insurance.

Def. 9. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Def. 10. **Biological attack** or **weapons** the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 11. **Catastrophic Event** means and includes Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood, Inundation and Earthquake

Def. 12. **Certificate of Insurance (COI)** is a document pertaining to the Insured Person. It is attached to and forms part of this Policy. The COI must be read in conjunction with the Policy Wordings

(Policy Terms and Conditions) for complete understanding and clarity on coverages and the limits of such coverages applicable to the Insured Persons. The COI captures

(a) the details of all the Insured Persons under the Policy,
(b) Any Special conditions,
(c) Applicable Waiting periods,
(d) Any Special Exclusions or Insuring terms,
(e) The names of the coverages that are in force and applicable under this policy,
(f) The Sum Insured stipulated against coverages that are in force,
(g) The Policy Period and the limits upto which benefits are payable under the Policy.
(h) The COI also includes any Annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time

Def. 13. **Chemical attack** or **weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 14. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule/Certificate of Insurance

Def. 15. **Coma/Comatose State** means a state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
iv. The condition has to be confirmed by a specialist medical practitioner.
v. Coma resulting directly from alcohol or drug abuse is excluded.

Def. 16. **Dependent Child / Children** means a child (natural or legally adopted), who is unmarried, aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 17. **Dependents** means only the family members listed below:

a) **Your** legally married spouse as long as she continues to be married to You
b) **Your** children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households;
c) **Your** natural parents or parents that have legally adopted You, and **Your** parent in laws

Def. 18. **Dependent Parents** means Your natural parents, parents that have legally adopted you or **Your** parents in law.

Def. 19. **Family Floater** means a Policy described as such in the Policy Schedule where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date on floater Sum Insured basis.

Def. 20. **Life threatening situation** shall mean a serious medical condition or symptom resulting from Injury or Illness which is not pre-existing disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

Def. 21. **IInsured Person** means You and the persons named in the Policy Schedule who are insured under the Policy.

Def. 22. **Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 23. **Nuclear attack** means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

Def. 24. **OPD Treatment** is a type of 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. 25. **Policy** means Your statements in the proposal form / enrolment form (which are the basis of this Policy), this policy wording (including endorsements, if any), and the Policy Schedule / Certificate of Insurance.

Def. 26. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Certificate of Insurance.

Def. 27. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 28. **Policy Schedule** is a document pertaining to the Master / Group Policyholder. It is attached to and forms part of this Policy. The Policy Schedule must be read in conjunction with the Policy Wordings (Policy Terms and Conditions) for complete understanding and clarity on coverages and the limits of such coverages applicable to the Insured Persons. The Policy Schedule captures

(a) the details of all the Insured Persons under the Policy,
(b) Any Special conditions,
(c) Applicable Waiting periods,
(d) Any Special Exclusions or Insuring terms,
(e) The names of the coverages that are in force and applicable under this policy,
(f) The Sum Insured stipulated against coverages that are in force,
(g) The Policy Period and the limits upto which benefits are payable under the Policy.
(h) The Policy Schedule also includes any Annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time

Def. 29. **Policy Year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

Def. 30. **Preventive Health Check-up -**Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Def. 31. **Second Medical Opinion** means a procedure where by upon request of Insured Person, an independent Medical Practitioner reviews and opines on treating Medical Practitioner's recommendation as to care and treatment of Insured Person by reviewing Insured Person's medical status and history

Def. 32. **Sum Insured** mentioned against a coverage / section represents Our maximum liability with regards to that coverage / section for a given Policy Year. It is arrived at by adding the Base Sum Insured with the below mentioned coverages if in force and applicable to the cover

i. Double Sum Insured for Critical Illness (wherever applicable)

ii. Accumulated Cumulative bonus

iii. Accumulated Inflation Protector

iv. Secure Benefit

v. Restore benefit

vi. Double Restore benefit OR Unlimited Restore Benefit

In case there is no accumulation under the coverages mentioned above or if they are not in force / not applicable their amount shall be considered as zero. In case of Individual Policies Sum Insured shall be on per Insured Person basis. In case of Family Floater policies, a common Sum Insured shall be available on a floating basis amongst all the Insured Persons. Sum Insured for a coverage / section shall be on a Policy Year basis unless specified otherwise in the coverage or mentioned in the Policy Schedule / Certificate of Insurance. Sum Insured shall reduce during the Policy Year in case of a claim.

Def. 33. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

Def. 34. **Time Deductible** means a cost sharing requirement under a health insurance Policy that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer. A Time Deductible does not reduce the Sum Insured

Def. 35. **We/Our/Us/Insurer/Company** means the HDFC ERGO General Insurance Company Limited

Def. 36. **You/Your** means the Insured Person named in the Certificate of Insurance who is insured under the Policy

III. CRITICAL ILLNESS STANDARD DEFINITIONS [Applicable to Section 2.A.II.10, 22 & Section 2.B.3.]

1. Cancer of specified severity

A malignant tumour 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 leukaemia, lymphoma and sarcoma.

The following are excluded:

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, 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 tumours 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 Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
II. The following are excluded:
   a. Angioplasty and/or any other intra-arterial procedures

3. Myocardial Infarction (First Heart Attack of specified severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   b. New characteristic electrocardiogram changes
   c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   a. Other acute Coronary Syndromes
   b. Any type of angina pectoris
   c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. Kidney failure requiring regular dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

5. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

a. One of the following human organs: lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ,
b. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:
a. Other stem-cell transplants
b. Where only islets of langerhans are transplanted

6. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

7. Permanent Paralysis of Limbs

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

8. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.
b. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
a. Transient ischemic attacks (TIA)
b. Traumatic injury of the brain
c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

9. Coma of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i) no response to external stimuli continuously for at least 96 hours;
   ii) life support measures are necessary to sustain life; and
   iii) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner.
   a. Coma resulting directly from alcohol or drug abuse is excluded.

10. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or diseaseaffected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

11. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

12. Major Head Trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   i) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv) Mobility: the ability to move indoors from room to room on level surfaces;
   v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi) Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
   i) Spinal cord injury;

IV. CRITICAL ILLNESS STANDARD DEFINITIONS [Applicable to Section 2.A.II.18]

1. Kidney failure requiring regular dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

2. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolisation from an extra cranial source.
b. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

a. Transient ischemic attacks (TIA)
b. Traumatic injury of the brain
c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

3. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

4. Cancer of specified severity

A malignant tumour 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 leukaemia, lymphoma and sarcoma.

The following are excluded:

ix. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
x. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
xi. Malignant melanoma that has not caused invasion beyond the epidermis;
xii. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
xiii. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
xiv. Chronic lymphocytic leukaemia less than RAI stage 3
xv. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
xvi. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

5. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

V. CRITICAL ILLNESS SPECIFIC DEFINITIONS [Applicable to Section 2.A.II.18]

1. Encephalitis

I. Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Medical practitioner who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

2. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Medical practitioner who is a qualified specialist.

3. Total Replacement of Joints

Surgical replacement of a joint with an artificial prosthesis performed under general or regional anesthesia in a Hospital by an orthopaedic surgeon.

4. Cirrhosis of Liver

I. Cirrhosis is a late stage of scarring (fibrosis) of the liver caused by many forms of liver diseases and conditions, such as hepatitis.
II. Characterized by at least three of the following conditions: I. Jaundice ii. Ascites iii. Bleeding from esophageal varices
III. Should be certified by a hepatologist and supported by a MRI and Ultrasound and elevated Bilirubin levels.
IV. Drug or alcohol abuse leading to liver cirrhosis is excluded.

VI. SPECIFIC DEFINITIONS FOR VECTOR BORNE DISEASES [Applicable to Section 2.B.8,9,10]

1. **Dengue** Fever Diagnosis of Dengue Fever should be confirmed by a Medical Practitioner and Laboratory examination result countersigned by a pathologist/ microbiologist confirms the following:
   - Immunoglobulins/PCR test showing positive results for Dengue

2. **Malaria** Diagnosis of Malaria should be confirmed by a Medical Practitioner with confirmatory tests indicating presence of Plasmodium Falciparum/ Vivax/ Malariae in the patient's blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test)

3. **Other Vector Borne Diseases**
   a. **Chikungunya**
   Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash. The diagnosis must be documented by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti chikungunya antibodies.

   b. **Japanese Encephalitis**
   Characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis. To confirm Japanese Encephalitis (JE) infection and to rule out other causes of encephalitis, a laboratory testing of serum or preferably cerebrospinal fluid shall be required. The diagnosis must be confirmed by a Medical Practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

   c. **Kala-azar**
   Visceral leishmaniasis, also known as Kala-azar, is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia. The diagnosis must be confirmed by a Medical Practitioner and by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for Kala-azar should clearly indicate the presence of this disease

   d. **Lymphatic Filariasis**
   Commonly known as Elephantiasis, must be confirmed by a Medical Practitioner and the laboratory examination countersigned by a pathologist must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

   i. Lymphoedema
   ii. Elephantiasis
   iii. Scrotal swelling

   <u>Specific condition for this cover:</u>

i. Filariasis will be payable once in lifetime

e. Zika Virus

People with Zika virus disease can have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache.

A diagnosis of Zika virus infection should be confirmed by a Medical Practitioner and by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC (Centers for Disease Control and Prevention) or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results

SECTION 2 - BENEFITS COVERED UNDER THE POLICY

A. BASE INDEMNITY COVERAGE

Section 2.A. Base indemnity coverage can be opted on a standalone basis. If opted, all sub-coverages under Section 2.A.I. Hospitalization Expenses section shall be applicable by default. However, the sub-coverages can be modified at inception or renewal as per options specified in the Proposal Form. The specific limits of each coverage under Section 2.A.I. Hospitalization Expenses shall be as stipulated in the Policy Schedule / Certificate of Insurance.

I. HOSPITALIZATION EXPENSES

1) We will indemnify expenses incurred by the Insured person on Medically Necessary Hospitalization necessiated due to an Illness or Injury sustained during the Policy Year.

2) The Insured person shall be indemnified for expenses as detailed in each coverage below if the same are in force as per the Policy Schedule / Certificate of Insurance.

3) We shall indemnify expenses upto the Sum Insured stipulated against Hospitalization Expenses Section in the Policy Schedule / Certificate of Insurance.

4) Claim admissible under any of the below listed sub-coverages of Hospitalization Expenses shall reduce the Sum Insured stipulated against Hospitalization Expenses in the Policy Schedule / Certificate of Insurance.

COVERS UNDER HOSPITALIZATION EXPENSES

a. Medical Expenses

i. **Room Rent** and boarding charges at actuals (unless specified otherwise in the Policy Schedule / Certificate of Insurance)
ii. **Intensive Care Unit** charges at actuals (unless specified otherwise in the Policy Schedule / Certificate of Insurance)
iii. Consultation fees & Nursing charges
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
v. Medicines, drugs and consumables
vi. Diagnostic procedures related to admissible hospitalization claim
vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

b. Pre-Hospitalization Medical Expenses Cover

We will indemnify the **Pre-Hospitalization Medical Expenses** incurred during the 30 days (unless specified otherwise in the Policy Schedule / Certificate of Insurance) immediately before **Hospitalization** of an **Insured Person.**

c. Post-Hospitalization Medical Expenses Cover

We will indemnify the **Post-HospitalizationMedical Expenses** incurred upto 60 days (unless specified otherwise in the Policy Schedule / Certificate of Insurance) from the date the **Insured Person** is discharged from the **Hospital.**

d. Domiciliary Hospitalization

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

e. Organ Donor Expenses

We will indemnify **Medical Expenses** covered under Section 2.A.I.a towards organ donor's **Hospitalization** for harvesting of the donated organ where an **Insured Person** is the recipient subject to condition that;

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/or Regulations.
ii. **Hospitalization** Claim under Section 2.A.I.a is admissible under the coverage for the **Insured Person**
iii. The Organ Donor's **Pre-Hospitalization** and **Post-Hospitalization Medical Expenses** are excluded under the **Policy**.
iv. Any other **Medical Expenses** or **Hospitalization** consequent to the harvesting is excluded under the Coverage.

f. Day Care Procedures

We will indemnify the **Medical Expenses** under Section 2.A.I.a on **Hospitalization** of **Insured Person** in **Hospital** or **Day Care Centre** for **Day Care Treatment.**

g. Road Ambulance Cover (India only)

For each admissible claim under Section 2.A.I.a and Section 2.A.I.f, **We** will indemnify 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**

Specific Conditions applicable to Road Ambulance Cover

i. The indemnification of Roan Ambulance expenses shall be upto INR 2000 on a per hospitalization basis (unless specified otherwise in the Policy Schedule / Certificate of Insurance).

II. OPTIONAL COVERS UNDER SECTION 2.A.I. 'HOSPITALIZATION EXPENSES'

Insuring Clause

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

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

All coverages under Section 2.A.II. 'Optional covers under hospitalization expenses' are optional in nature. These coverages specifically pertain only to Section 2.A. 'Base Indemnity coverage' and can be opted only if the Base section is opted

1. Pre-Existing Disease Waiting period Modification Option

   On availing this option, **Waiting Period** listed under Section 3.A.I. shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

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

2. Specified Disease / Procedure Waiting Period Modification Option

   On availing this option, **Waiting Period** listed under Section 3.A.II. shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

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

3. Modification of General Waiting Period

   On availing this option, **General Waiting Period** of 30 days listed under Section 3.A.III. shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

   By availing this option, General Waiting Period of 30 days will be waived off even in case of claims due to illnesses. All other terms and Conditions of the **Policy** shall remain unaltered.

4. Modification of Pre and Post Hospitalization Medical Expenses

   On availing this option, **Pre** and **Post Hospitalization Medical Expenses** limit mentioned under Section 2.A.I.b. and 2.A.I.c. respectively, shall stand modified and shall be as mentioned in the **Policy Schedule** / Certificate of Insurance.

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

5. Room Rent and ICU Modification Option

   On availing this option, Room Rent and ICU limits under Section 2.A.I.a. shall stand modified and shall be as mentioned in the Policy Schedule / Certificate of Insurance.

Proportionate Deduction

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

6. Road Ambulance Modification Option

On availing this option, the per hospitalization Road Ambulance limit specified under Section 2.A.I.g. shall stand modified and shall be as mentioned in the **Policy Schedule** / Certificate of Insurance.

7. Co-Payment

On availing this option, **Co-Payment** as mentioned in the **PolicySchedule** / Certificate of Insurance will be applied on admissible claim only on the coverages mentioned in the below table

Section No.	Name of Cover
Section 2.A.I. - Hospitalization Expenses	Section 2.A.I.a. – Medical Expenses Section 2.A.I.b. – Pre-Hospitalization Medical Expenses Cover Section 2.A.I.c. – Pre-Hospitalization Medical Expenses Cover Section 2.A.I.d – Domiciliary Hospitalization (if in force) Section 2.A.I.e. – Organ Donor Expenses Section 2.A.I.f. – Day Care procedures Section 2.A.I.g. – Road Ambulance Cover (if in force)
Section 2.A.II.8.	Alternative Treatment (if in force)
Section 2.A.II.11.	Restore benefit (if in force)
Section 2.A.II.12.	Double Restore benefit (if in force)
Section 2.A.II.13.	Cumulative bonus (if in force)
Section 2.A.II.22.	Double Sum Insured for Critical Illness (if in force)
Section 2.A.II.26.	Home Healthcare (if in force)
Section 2.A.II.28.	Protect Benefit (if in force)
Section 2.A.II.29.	Inflation Protector (if in force)
Section 2.A.II.33	Secure Benefit (if in force)
Section 2.A.II.34	Unlimited Restore Benefit (if in force)

8. Alternative Treatment

We will indemnify **Medical Expenses** covered under Section 2.A.I., only on **Medically Necessary In-patient care treatment** of **Insured Person** during the Policy Year in an **AYUSH Hospital** for only the below listed **Alternative Treatments** prescribed by the treating **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 Section 2.A.I. (Hospitalization Expenses).
Details mentioned in the Policy Schedule against this cover shall be superceded by the above wordings.

Specific Conditions applicable to Alternative Treatment

a. Exclusion pertaining to Non-allopathic treatments shall be superceeded upto the extent of coverage provided under Alternative Treatment cover

b. Claims admissible under this cover shall therefore reduce the Base Sum Insured of Section 2.A.I. (Hospitalization Expenses)

9. Deletion of Domiciliary Hospitalization

On availing this option, Domiciliary Hospitalization under Section 2.A.I.d. shall stand deleted under the **Policy**.

10. Second Medical Opinion for Major Illness

We shall provide a **Second Medical Opinion** of a **Medical Practitioner** from our Network in case the Insured Person requests for a Second Medical Opinion during the Policy Year for any of the below listed **Major Illnesses**.

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

Specific Conditions applicable to Second Medical Opinion for Major Illness

a. This is a service benefit that we shall provide from within our Network or through our Network Service provider

b. This Benefit is not available on Reimbursement basis

c. We shall provide only one Second Medical Opinion in a given Policy Year.

d. Incase a claim is paid during the Policy Year under this cover the coverage shall be replenished post completion of the Policy Year.

e. In no event shall HDFC ERGO be liable for any direct, indirect, punitive, incidental, special consequential damages or any other damages whatsoever caused to the Policyholders/Insured of HDFC ERGO while receiving the services from Network providers.

11. Restore Benefit

In the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year, the Company shall reinstate only the utilized portion of the Base Sum Insured of Section 2.A.I. (as applicable under the current Policy Year)

Specific Conditions applicable to Restore Benefit

a. This benefit shall not be applicable for hospitalization under Any One Illness.
b. The Base Sum Insured reinstatment under the Restore Benefit would be triggered only upon complete or partial utilization of the Base Sum Insured by the way of first claim admissible under coverages listed under Annexure 2, and shall be available only for subsequent claims that may arise thereafter in the remainder of the Policy Year.
c. This benefit can trigger multiple times however the maximum amount of reinstatement in a Policy Year under this benefit shall never exceed 100% of Base Sum Insured of Section 2.A.I. for that Policy Year (unless Double Restore OR Unlimited Restore is also opted)
d. The reinstated amount can only be used for claims under coverages mentioned in Annexure 2
e. The reinstated amount can be utilized for both same and different Illness / Injury and by any Insured person
f. Any unutilized reinstated amount, in whole or in part, will not be carried forward to the subsequent Policy Years.
g. In case of a family floater policy, the Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

Illustration

Number of Claim	Claim amount	Available Benefit Limit			Admissible claim amount	Utilisation of Sum Insured
		Base Sum Insured	Cumulative Bonus*(on completion of 1st policy year)	Restore Benefit		
1st claim	3,00,000	5,00,000	50,000	0	3,00,000	Base (partial)
2nd claim	7,00,000	2,00,000	50,000	3,00,000	5,50,000	Base (balance) + Cumulative Bonus + Restore Benefit (partial)
3rd claim	3,00,000	-	-	2,00,000	2,00,000	Restore Benefit (partial)

*if opted

12. Double Restore Benefit

Post complete utilization of **Your** Base **Sum Insured**, if **You** partially or completely utilize your Restore Benefit **Sum Insured** the utilized portion of your Restored Benefit shall be reinstated.

Specific Conditions applicable to Double Restore Benefit

a. This benefit shall not be applicable for hospitalization under Any One Illness.
b. Reinstatement under Double Restore Benefit would be triggered only upon complete or partial utilization of the Restore Benefit, and shall be available only for subsequent claims that may arise thereafter in the remainder of the Policy Year.
c. The maximum amount of reinstatement in a Policy Year that Double Restore benefit shall provide will never exceed the Base Sum Insured of Section 2.A.I. for that Policy Year
d. The reinstated amount under this benefit can only be used for claims under covergaes mentioned in Annexure 2
e. The reinstated amount under this benefit can be utilized for both same and different Illness / Injury and by any Insured person
f. Any unutilized reinstated amount under this benefit, in whole or in part, will not be carried forward to the subsequent Policy Years.
g. This benefit can be opted only if Restore benefit (Section 2.A.II.11) is opted
h. In case of a family floater policy, the Double Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

Illustration

Number of Claim	Claim amount	Available Benefit Limit				Admissible claim amount	Utilisation of Sum Insured
		Base Sum Insured	Cumulative Bonus*(on completion of 1st policy year)	Restore Benefit	Double Restore Benefit		
1st claim	3,00,000	5,00,000	50,000	0	0	3,00,000	Base (partial)
2nd claim	7,00,000	2,00,000	50,000	3,00,000	0	5,50,000	Base (balance) + Cumulative Bonus + Restore Benefit (partial)
3rd claim	6,00,000	-	-	2,00,000	3,00,000	5,00,000	Restore Benefit (partial) + Double Restore Benefit (partial)
4th claim	3,00,000	-	-	-	2,00,000	2,00,000	Restore Benefit (partial) + Double Restore Benefit (partial)

*if opted

13. Cumulative Bonus

On completion of each Policy Year with Us, Insured Persons shall be granted Cumulative Bonus as specified in the **Policy Schedule**/Ceritficate of Insurance irrespective of any claims made during the Policy Year

Specific Conditions applicable to Cumulative Bonus

a. Cumulative Bonus shall be calculated as a percentage of the expiring Policy Year's Base Sum Insured of Section 2.A.I.
b. **Cumulative Bonus** can be accumulated upto the maximum limit mentioned in the **Policy Schedule**/Certificate of Insurance.
c. **Cumulative Bonus** accrued will be available at Certificate of Insurance Level and shall be applicable only to **Insured Person(s)** covered under the expiring Coverage and who continue to remain insured on **Renewal**.
d. The accrued Cumulative Bonus can be utilized only for covers mentioned in Annexure 2

14. Maternity Cover

We will indemnify **Maternity Expenses** incurred by the **Insured Person** under Section 2.A.I.a,incurred during the **Policy** Year.

Specific Conditions applicable to Maternity Cover

a. On opting this cover, exclusion pertaining to Maternity shall be superceded to the extent of coverage provided under this benefit

b. Under Maternity cover we shall only cover the medical expenses as detailed under Section 2.A.I.a.

c. Indemification of Maternity Expenses under this benefit shall be covered only upto the limit specified against this cover in the Policy Schedule / Certificate of Insurance. Furthermore, Maternity Cover does not have an independent Sum Insured, hence any claim admissible under this cover shall reduce the Sum Insured of Section 2.A.I.

d. An additional waiting period of 48 months (unless specified otherwise in the Policy Schedule / Certificate of Insurance against this cover) starting from the date of commencement of this Cover under this Policy shall apply for all Claims under Maternity Cover.

Specific Exclusions applicable to Maternity Cover

We will not make payment for any claim in respect of any **Insured Person** caused by, any of the following unless expressly stated to the contrary in the **Policy Schedule** / Certificate of Insurance.

i. **Pre-Hospitalization** and **Post-Hospitalization Medical Expenses** are not payable under this cover.
ii. We will not pay any expenses related to ectopic pregnancy under this cover. Ectopic pregnancy will be covered as a part of expenses under Section B.I only.
iii. Treatment for impotency, treatment to effect infertility, surrogate or vicarious pregnancy, voluntary termination of pregnancy, procedures to assist birth control, contraceptive supplies.

15. Pre and Post Natal Expenses

On availing this option, **We** will indemnify **Medical Expenses** incurred during the Policy Year for **Pre** and **Post Natal** expenses upto the Base Sum Insured of Section 2.A.I. Pre and Post Natal Expenses cover does not have an independent Sum Insured, hence any claim admissible under this cover shall reduce the Sum Insured of Section 2.A.I.

16. Baby Cover from Day 1

We will indemnify **Medical Expenses** incurred on Hospitalization during the Policy Year towards **Medically Necessary Treatment** of the Insured Person's **New Born Baby,** as advised by the treating **Medical Practitioner,** up to the Base Sum Insured of Section 2.A.I.

Specific Conditions applicable to Baby Cover from Day 1

a. Baby Cover from Day 1 does not have an independent Sum Insured, hence any claim admissible under this cover shall reduce the Sum Insured of Section 2.A.I.

b. We will indemnify medical expenses under this cover only for the 1st 90 days from the birth of the new born.

c. For continued coverage post 90 days under the Policy, the Policyholder must

   i. inform us in writing that he wishes to add the new born as an Insured Person (dependent child) under this Policy and

   ii. pay the requisite premium within the 1st 90 days from the birth of the new born.

   iii. Continued coverage shall be offered subject to our underwriting policy

17. Infertility Cover

We will indemnify **Medical Expenses** as detailed under Section 2.A.I.a. that are incurred during the Policy Year for infertility treatment, assisted reproductive treatments undertaken by Insured Person on advice of a **Medical Practitioner.**

Specific Conditions applicable to Infertility Cover

a. On opting this cover, exclusion pertaining to infertility treatment & assisted reproductive treatments shall be supercceded to the extent of overage under this benefit

b. Indemnification of expenses under this cover shall be as specified in the **Policy Schedule** / Certificate of Insurance.

c. Infertility Cover does not have an independent Sum Insured, hence any claim admissible under this cover shall reduce the Sum Insured of Section 2.A.I.

18. Corporate Buffer

On availing this option, **We** will provide for a Corporate Buffer during the Policy Year up to the limits and terms as specified in the the **Policy Schedule**

Specific Conditions applicable to Corporate Buffer

a. All other terms and conditions of the Policy shall remain unaltered

b. The coverage under this benefit will be applicable for **Insured Persons** who have exhausted their Sum Insured limits

c. The policyholder will have an option to choose Corporate Buffer from below listed options:

- Option 1: Corporate Buffer Restricted to Critical Illness (listed in Table A below) up to the Sum Insured
- Option 2: Corporate Buffer Restricted to Critical Illness (listed in Table A below) without Sum Insured restriction
- Option 3: Corporate Buffer up to the Corporate Buffer Sum Insured
- Option 4: Corporate Buffer – no restriction on sum insured

Table A	
S.No	**Name of Critical Illness**
1	Kidney failure requiring regular dialysis
2	Stroke resulting in permanent symptoms
3	Open chest CABG
4	Cancer of specified severity
5	Encephalitis (Viral)
6	Brain Surgery
7	Total Replacement of Joints
8	Cirrhosis of Liver
9	Injury leading to brain surgery
10	Third Degree Burns

19. Outpatient Treatment (OPD) Cover

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

Specific Conditions applicable to OPD Cover

a. On opting this cover, exclusion pertaining to OPD treatments shall be superceded to the extent of coverage provided under this benefit.
b. OPD Cover has an independent Sum insured and claim admissible under this benefit shall be covered only upto the Sum Insured stipulated against this cover in the **Policy Schedule** / Certificate of Insurance.

20. Aggregate Deductible

On availing this option, the **Insured Person** shall bear an amount equal to the **Aggregate Deductible** as specified in the **Policy Schedule /** Certificate of Insurance for admissible claims made under coverages mentioned in Annexure 2 in a **Policy Year**.

Specific Conditions applicable to Aggregate Deductible

a. The liability of the Company to pay the admissible Claims in a given **Policy Year** will commence only once **Aggregate Deductible** has been exhausted.

b. This cover shall apply on an annual aggregate basis and not on per claim basis.

c. In case of an Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year

d. In case of a family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year

e. In case Aggregate Deductible of INR 10 Lac or above is opted Insured Person shall not be eligible for the below benefits

   i. Cumulative bonus

   ii. Inflation Protector

   iii. Secure Benefit

   iv. Restore benefit

   v. Double Restore benefit OR Unlimited Restore Benefit

f. Aggregate Deductible shall apply only to covers mentioned in Annexure 2

21. Disease Capping

On availing this option, Claims under Section 2.A.I.a., for **Illnesses** as specified below shall be admissible maximum upto the Sub-limits as mentioned in the Policy Schedule / Certificate of Insurance. Limit shall be on Per Illness & Per Policy Year basis. The disease category opted shall be mentioned in the Policy Schedule / Certificate of Insurance.

Disease Category I	
Sr. No.	Name of Disease / Disease pertaining to
1.	Heart
2.	Cataract
3.	Cholecystectomy
4.	Hysterectomy
5.	Joint Replacement
6.	Genito Urinary
7.	Cancer (All types)
8.	Appendicitis
9.	Chronic Renal Failure
10.	Intervertebral Disc

Disease Category II	
Sr. No.	Name of Disease
1.	Hernia
2.	Amputation
3.	Long Bone Fractures
4.	Fissure and Fistula
5.	Accident
6.	Coma
7.	Deviated Nasal Septum

22. Double Sum Insured for Critical Illness

This cover shall trigger only if any of the Insured Persons is diagnosed with any of the below listed **Critical Illnesses.** In such an event, we shall provide him an additional Sum Insured for treatment of any of the listed Critical Illnesses. This coverage shall work on an indemnity basis.

Specific Conditions applicable to Double Sum Insured for Critical Illness

a. Claim under this benefit shall be admissible only if, first diagnosis of the listed Critical Illness is during the Policy Year wherein this benefit was in force.
b. Claim under this benefit shall be admissible only if we have accepted a hospitalization claim under Section 2.A.I.a.
c. The additional Sum Insured provided under this cover shall be equal to the Base Sum Insured of Section 2.A.I.
d. The additional Sum Insured provided under this cover shall be granted only once in a given Policy Year
e. The additional Sum Insured can be utilised only by the **Insured Person** diagnosed with the listed **Critical Illness**
f. Any unutilized amount (if any) under this benefit can further be utilized by any of the **Insured Person** diagnosed with any of the defined **Critical Illnesses**.
g. Any unutilized amount (if any) under this benefit shall not be carried forward to the next Policy Year.
h. When the **Insured Person** is admitted for any other illness other than the defined **Critical Illnesses** under this benefit and in this course of admission he has been diagnosed subsequently with any of the defined **Critical Illness**, he shall be indemnified under this coverage.
i. Incase a claim is paid during the Policy Year under this cover the coverage shall be replenished post completion of the Policy Year.

CRITICAL ILLNESSES COVERED			
1	Cancer of specified severity	3	Major Organ/Bone Marrow Transplant
2	Myocardial Infarction (First Heart Attack of specific severity)	4	Stroke resulting in Permanent Symptoms

23. Preventive Health Check Up

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

.

Specific Conditions applicable to Preventive Health Check Up

a. Preventive Health Check Up Cover has an independent Sum Insured and claim under this coverage shall have no impact on any other coverage ubder this Policy.
b. This coverage will be applicable as per the eligibility conditions mentioned in the **Policy Schedule**/Certificate of Insurance.
c. In case of Annual Eligibility, Preventive Health Check Up shall be available every year, post completion of the first Policy Year with us.
d. In case of Annual Eligibility, the percentage and limit will be calculated on expiring Base Sum Insured of Section 2.A.I. and will be only applicable to **Insured Person** covered under expiring Coverage
e. In case of Eligibility at the end of each block of continuous three Policy Years, the percentage and limit will be calculated on Average **Sum Insured** during block of three years and will be only applicable to **Insured Persons** covered during all previous 3 years.
f. There is no specific list of tests applicable to this cover. Tests falling under the purview of a Preventive Health Check Up shall be payable.

24. Air Ambulance (India only)

The Company shall indemnify the medical expenses incurred on availing Air Ambulance services during the Policy Year to transport the Insured Person from the site of first occurrence of the Illness/Accident to the nearest Hospital for Emergency Care.

Specific Conditions applicable to Air Ambulance (India only)

a. Air Ambulance service means transportation of the Insured Person in an airplane or helicopter, for life threatening Emergency Care which requires immediate and rapid Ambulance transportation, that ground transportation cannot provide
b. Indemnification of Air Ambulance expenses shall be at actuals. Claim under this benefit shall not reduce the Sum Insured of Section 2.A.I.
c. The Air Ambulance transportation must be advised in writing by a Medical Practitioner.
d. Medically Necessary Treatment must not be available at the location where the Insured Person is situated at the time of emergency.
e. The air Ambulance provider should be a registered entity in India.
f. No return transportation to the Insured Person's Home or elsewhere by the air Ambulance will be covered under this cover.
g. A claim under this cover shall be admissible only if such transportation has resulted into a claim being accepted under
    i. Medical Expenses (Section 2.A.I.a.) OR;
    ii. Day Care Procedures (Section 2.A.I.f.)
h. Geography of this benefit is restricted to India only

25. Air Ambulance (outside India only)

The Company shall indemnify the medical expenses incurred on availing Air Ambulance services during the Policy Year to transport the Insured Person from the site of first occurrence of the Illness/Accident to the nearest Hospital.

Specific Conditions applicable to Air Ambulance (outside India only)

a. Air Ambulance service means transportation of the Insured Person in an airplane or helicopter, for life threatening Emergency Care which requires immediate and rapid Ambulance transportation, that ground transportation cannot provide
b. Indemnification of Air Ambulance expenses shall be at actuals. Claim under this benefit shall not reduce the Sum Insured of Section 2.A.I.
c. The Air Ambulance transportation must be advised in writing by a Medical Practitioner.
d. Medically Necessary Treatment must not be available at the location where the Insured Person is situated at the time of emergency.
e. The air Ambulance provider should be an entity registered with the government of the country it operates in.
f. No return transportation to the Insured Person's Home or elsewhere by the air Ambulance will be covered under this cover.
g. A claim under this cover shall be admissible only if such transportation has resulted into a claim being accepted under
    i. Global Emergency Hospitalization Cover [outside India only] (Section 2.A.II.33.) OR
    ii. Global Hospitalization Cover [outside India only] (Section 2.A.II.34.).
h. Geography of this benefit is restricted to outside India only.

26. Home Healthcare

The Company shall indemnify the Medical Expenses incurred by the Insured Person on availing treatment at Home during the Policy Year

Specific Conditions applicable to Home Healthcare

i. Home Healthcare treatment must be prescribed in writing by the treating Medical Practitioner.
ii. The treatment must be such that in normal course it would have required In-patient Care at a Hospital, and a claim would have been admissible under Section 2.A.I.a.
iii. The treatment must be pre-authorized by Us as per the claim procedure given below
iv. Records of the treatment administered, duly signed by the treating Medical Practitioner, must be maintained for each day of the Home treatment.
v. This Cover is not available on reimbursement basis.
vi. There is no separate Sum Insured for this cover. Any claim triggered under this benefit shall reduce the Sum Insured of Section 2.A.I.

Specific Claim procedure applicable to Home Healthcare

a. Notification of Claim

   Notice with full particulars must be sent to the Company at least 48 hours prior to availing treatment under Home HealthCare.

b. Procedure for Cashless Claims
   i. On receipt of duly filled pre authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company.
   ii. On receipt of the complete documents, the Company may:
      - Issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, OR
      - Reject the request for pre-authorization specifying reasons for the rejection.

27. Convalescence Benefit

We shall pay an additional Lumpsum amount as specified in the Certificate of Insurance / Policy Schedule if an Insured Person is hospitalized during the Policy Year for a period of 10 consecutive and continuous days or more, following an Illness or Injury.

Specific Conditions applicable to Convalescence Benefit

i. This benefit is payable only once in a Policy Year.

ii. Incase a claim is paid during the Policy Year under this cover the coverage shall be replenished post completion of the Policy Year.

iii. A claim under this cover shall be admissible only if we have accepted a claim under
   a. Medical Expenses (Section 2.A.I.a.) OR;
   b. Day Care Procedures (Section 2.A.I.f.)

28. Protect Benefit

The Company shall indemnify the Insured Person upto the Sum Insured, for Non-Medical Expenses listed under List I of Annexure I and incurred during the Policy Year.

Specific Conditions applicable to Protect Benefit

a. Claim under this benefit shall be payable only if we have accepted and paid a claim under the covers mentioned in Annexure 2

b. There is no separate Sum Insured for this cover. Any claim triggered under this benefit shall reduce the Sum Insured of Section 2.A.I.

29. Inflation Protector

This cover protects your Base Sum Insured against rising inflation. It links the Base Sum Insured of Section 2.A.I. to the Consumer Price index (CPI). Thus, amount accrued under this benefit shall be computed as per the below formula:

a. **Amount Accrued under Inflation Protector post completion of 1st Policy Year** = (Base Sum Insured x Inflation rate of expiring Policy Year)

b. **Amount Accrued under Inflation Protector post completion of 2nd Policy Year** =

   (Base Sum Insured x Inflation rate of expiring Policy Year) + (Amount Accrued under Inflation Protector post completion of 1st Policy Year)

c. **Amount Accrued under Inflation Protector post completion of nth Policy Year** =

   (Base Sum Insured x Inflation rate of expiring Policy Year) + (Total Amount Accrued under Inflation Protector until completion of [n-1]th Policy Year)

Specific Conditions applicable to Inflation Protector

a. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organisation (CSO).

b. The accumulated amount under this coverage will lapse if the Policy is not renewed.

c. The accumulated amount under this coverage will never reduce once accrued.

d. There is no limit or capping upto which amount under this benefit can be accumulated

e. Accumulated amount under this benefit can only be used for claims under covers mentioned in Annexure 2

30. Compassionate Visit

If the Insured Person is Hospitalized for 5 continuous days or more during a Policy Year, we shall reimburse the cost of round trip tickets upto the limit mentioned in the Policy Schedule/Certificate of Insurance stipulated against this cover for any one Immediate Family Member to attend to the Insured Person's medical emergency during his hospitalization.

Specific Definition applicable to Compassionate Visit

Immediate Family Member means an Insured Person's legal spouse; siblings; siblings-in-law; parents; parents-in-law; legal guardian, children; who reside in India

Specific Conditions applicable to Compassionate Visit

a. We shall reimburse expenses for the cost of a round trip journey, undertaken by either
   i. Rail (upto AC 2 Tier) OR
   ii. Air (most basic economy class)
b. To and fro journey of Insured Person's Immediate Family member must be completed at most within 15 days from date of discharge
c. The round trip tickets booked must be by the most direct route possible from the City of Residence of the Immediate Family member to the place of Hospitalization of the Insured Person
d. This benefit shall trigger provided that no Immediate Family Member is present in the same city where the Insured Person is hospitalized.
e. Geography of this cover is restricted to India only.
f. A claim under this cover shall be admissible only if we have accepted a claim under
   i. Medical Expenses (Section 2.A.I.a.) OR;
   ii. Day Care Procedures (Section 2.A.I.f.)

31. Global Emergency Hospitalization Cover (outside India only)

On opting this cover, only the below mentioned benefits shall be extended for Emergency Hospitalization Expenses which are diagnosed and incurred outside India during the Policy Year. Limits of the extended benefits shall be as stipulated in the below table

Section	Name of the benefit	Coverage and Limits
Section 2.A.I.a.	Medical Expenses	Coverage upto Base Sum Insured of Section 2.A.I. By default Room rent & ICU coverage for this cover shall be At actuals
Section 2.A.I.f.	Day care procedures	Coverage upto Base Sum Insured of Section 2.A.I. for all day care procedures

Specific Conditions applicable to Global Emergency Hospitalization Cover (outside India only)

a. A Co-payment of 10% will apply separately for each and every claim under this cover.

b. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case to case basis.

c. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.

d. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

e. For any given trip, coverage shall be available only for the first 45 days from the start of a trip. Furthermore, total covered days in a Policy Year shall not exceed 90 days on a cumulative basis across trips.

   Note: Each trip shall be deemed to start during the Policy Year and from the date Insured Person finally boards the flight (scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket) to leave from India

f. There is no separate Sum Insured for this cover and any claim triggered under this benefit shall reduce the Base Sum Insured of Section 2.A.I.

g. Our Maximum liability under this cover shall never exceed the Base Sum Insured of Section 2.A.I. in a Policy Year.

h. Geography of this benefit is restricted to outside India only.

i. On opting this cover, exclusion pertaining to Medical treatments or hospitalization availed outside India shall be superceded to the extent of coverage provided under this benefit.

Specific Exclusions applicable to Global Emergency Hospitalization Cover (outside India only)

a. Any Planned treatments
b. In case we have paid a Hospitalization claim under this benefit, Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses related to the claim whether incurred overseas or within India are not payable under this Policy
c. Treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed

d. Medical treatment taken outside India, if that is the sole reason or one of the reasons for the journey

e. Any treatment of orthopaedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.

f. Oncological (Cancer) diseases

g. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction

32. Global Hospitalization Cover (outside India only)

On opting this cover, only the below mentioned benefits shall be extended for both planned and Emergency Hospitalization Expenses incurred outside India during the Policy Year. Limits of the extended benefits are as stipulated in the below table

Section	Name of the benefit	Coverage and Limits
Section 2.A.I.a.	Medical Expenses	Coverage upto Base Sum Insured of Section 2.A.I. By default Room rent & ICU coverage for this cover shall be at actuals
Section 2.A.I.f.	Day care procedures	Coverage upto Base Sum Insured of Section 2.A.I. for all day care procedures
Section 2.A.I.b.	Pre Hospitalization expenses	Coverage shall be for the number of days as stipulated in the Policy Schedule/Certificate of Insurance against Section 2.A.b.
Section 2.A.I.c.	Pre Hospitalization expenses	Coverage shall be for the number of days as stipulated in the Policy Schedule/Certificate of Insurance against Section 2.A.c.

Specific Conditions applicable to Global Hospitalization Cover (outside India only)

a. A Co-payment of 10% will apply separately for each and every claim under this cover.

b. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case to case basis.

c. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.

d. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

e. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.

f. Only those Pre-hospitalization Medical Expenses and/ or Post-hospitalization Medical Expenses shall be admissible under this benefit that have been incurred and paid overseas. Such expenses should be related to an admissible overseas Hospitalization claim only (as per details in invoice/supporting documents).

g. Pre-hospitalization Medical Expenses and/ or Post-hospitalization Medical Expenses triggered due to an admissible overseas hospitalization but incurred in India shall not be payable under the Policy.

h. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of Section 2.A.I.

i. Geography of this benefit is restricted to outside India only.

j. On opting this cover, exclusion pertaining to Medical treatments or hospitalization availed outside India shall be superceded to the extent of coverage provided under this benefit.

k. Our Maximum liability under this cover shall never exceed the Base Sum Insured of Section 2.A.I. in a Policy Year.

33. Secure Benefit

An additional amount as specified in the Policy Schedule / Certificate of Insurance will be available instantly from Day 1 to the Insured Person for all claims admissible under covers mentioned in Annexure 2

Specific Conditions applicable to Secure Benefit

a. The amount of Secure Benefit shall only be linked to the Base Sum Insured of Section 2.A.I.

b. This Secure Benefit shall be applied only once during each Policy Year and any unutilized amount, in whole or in part will not be carried forward to the subsequent Policy Year.

c. The Secure Benefit can be utilized for any number of claims admissible under the Policy during the Policy Year.

d. In case of family floater policy, the Secure Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

e. The Secure Benefit will be applicable only after complete exhaustion of the below.

   i. Base Sum Insured of Section 2.A.I.

   ii. Double Sum Insured for Critical Illness (if applicable)

   iii. Cumulative bonus (if applicable)

   iv. Inflation Protector (if applicable)

34. Unlimited Restore Benefit

Post complete utilization of **Your** Base **Sum Insured**, if **You** partially or completely utilize your Restore Benefit **Sum Insured** the utilized portion of your Restored Benefit shall be reinstated.

Specific Conditions applicable to Unlimited Restore Benefit

a. This benefit shall not be applicable for hospitalization under Any One Illness.
b. Reinstatement under Unlimited Restore Benefit would be triggered only upon complete or partial utilization of the Restore Benefit, and shall be available only for subsequent claims that may arise thereafter in the remainder of the Policy Year.
c. This cover can trigger unlimited times.
d. The maximum amount of reinstatement in a Policy Year that Unlimited Restore benefit shall provide is infinite
e. The reinstated amount under this benefit can only be used for claims under covergaes mentioned in Annexure 2
f. The reinstated amount under this benefit can be utilized for any Illness / Injury and by any Insured person
g. Any unutilized reinstated amount under this benefit, in whole or in part, will not be carried forward to the subsequent Policy Years.
h. This benefit can be opted only if Restore benefit (Section 2.A.II.11) is opted
i. In case of a family floater policy, the Unlimited Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

35. Road Ambulance Cover (outside India only)

For each admissible claim under

a. Global Emergency Hospitalization Cover (outside India only) [Section 2.A.II.33] OR

b. Global Hospitalization Cover (outside India only) Section 2.A.II.34,

We will indemnify 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**

Specific Conditions applicable to Road Ambulance Cover

a. The indemnification of Road Amubualnce expenses shall be upto an additional Sum Insured as stipulated in the Policy Schedule / Certificate of Insurance against this benefit

b. Geography of this benefit is restricted to outside India only.

B. OTHER BASE COVERAGES

All covers under Section 2.B. Other Base Coverages can be opted on a standalone basis. It is not necessary that Section 2.A. Base Indemnity coverage must be opted to opt for any coverages stipulated under this section. Each coverage under Section 2.B. - Other Base Coverages shall have an independent Sum Insured (unless express stated otherwise under the coverage) and the same shall be as stipulated in the Policy Schedule / Certificate of Insurance.

1. HOSPITAL CASH

If **Insured Person** contracts **Illness** or sustains **Injury** during Policy Year**,** which results in **Medically Necessary**;

i. **Hospitalization OR**
ii. Domiciliary **Hospitalization OR**
iii. **Hospitalization** for **Alternative Treatments**

of an **Insured Person** within India, **We** will pay the per day **Sum Insured** as specified in the Schedule of Coverage on 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**.

Specific Conditions applicable to Road Ambulance Cover

a. Claim payout is subject to **Time Deductible** specified in the Schedule of Coverage on the **Policy Schedule/**Certificate of Insurance.

b. Claim payout shall be subject to the maximum number of days in a Policy Year as specified in the Schedule of Coverage on the **Policy Schedule/**Certificate of Insurance.

c. All Waiting Periods as specified in the **Policy Schedule/**Certificate of Insurance against this cover shall apply. Timeframe for these waiting periods shall be as specified against this cover in the **Policy Schedule /** Certificate of Insurance. Terms, conditions and clauses for the applicable waiting periods are provided under Section 3.A.

2. PERSONAL ACCIDENT COVER

I. Accidental Death

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

a. Disappearance

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

i. after the forced landing, stranding, sinking or wrecking of a conveyance in which **Insured Person** was known to be a passenger during **Policy Period** or;
ii. after and as a result of any **Catastrophic Event** during **Policy Period**

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

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

Specific Conditions applicable to Accidental Death

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

II. Permanent Disablement

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

BENEFIT TABLE A

S.No	The Disablement	*% of Sum Insured Payable*
1	***Permanent Total Disablement***	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two ***Limbs*** (physical severance of Limbs)	100%
4	Permanent Total ***Loss of Sight*** in both eyes	100%

5	Permanent Total ***Loss of Sight*** of one eye and one ***Limb*** *(*physical severance of Limbs)	100%
6	Permanent Total ***Loss of Speech***	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total ***Loss of Mastication***	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out ***Daily Activities*** essential to life without full time assistance	100%
10	Permanent Total ***Loss of Hearing*** in both ears	75%
11	Permanent Total Loss of one ***Limb*** *(*physical severance of Limbs)	50%
12	Permanent Total ***Loss of Sight*** of one eye	50%

BENEFIT TABLE B

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

BENEFIT TABLE C

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

BENEFIT TABLE D

S.No	The Disablement	*% of Sum Insured Payable*
1	***Permanent Total Disablement***	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two ***Limbs*** *(*physical severance or the total and permanent loss of use)	100%
4	Permanent Total ***Loss of Sight*** in both eyes	100%
5	Permanent Total ***Loss of Sight*** of one eye and one ***Limb***	100%
6	Permanent Total ***Loss of Speech***	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total ***Loss of Mastication***	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out ***Daily Activities*** essential to life without full time assistance	100%
10	Permanent Total ***Loss of Hearing*** in both ears	75%
11	Permanent Total Loss of one ***Limb*** *(*physical severance or the total and permanent loss of use)	50%
12	Permanent Total ***Loss of Sight*** of one eye	50%
13	**Permanent Total *Loss of Hearing*** in one ear	15%
14	***Permanent Total Loss of the lens in one eye***	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	
a)	All – one foot	15%
b)	Big – both joints	5%
c)	*Big – one joint*	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%
23	**Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of**	75%

Specific Conditions applicable to Permanent Disablement

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

ii. Benefit under item 23 of Table D shall be determined by the independent **Medical Practitioner** who will certify the perecentage of **Sum Insured** payable taking into consideration the nature of the ***Injury*** and disability in conjunction with the stated percentages **Sum Insured** for more specific injuries shown in the Table of Benefits.
iii. Any claim amount admissible/paid during a given Policy year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims that may arise in the remainder of the Policy Year.
iv. The total amount payable in respect of more than one disablement due to the same **Injury** is arrived at by adding together the various percentages of **Sum Insured** shown in the Table of Benefits.
v. Only one Table out of Benefit Tables A, B, C, D stipulated above can be opted and the same shall be mentioned on the the Policy Schedule / Certificate of Insurance.

Specific Conditions applicable to Personal Accident Cover

i. This cover is offered only on Individual **Sum Insured** basis.
ii. In case Insured person opts for Personal Accident section, he would be eligible for both Accidental Death and Permanent Disablement
iii. The Sum Insured stipulated against Personal Accident section in the Policy Schedule / Certificate of Insurance is a common Sum Insured for Accidental Death and Permanent Disablement coverages
iv. In case we have paid a claim under Accidental Death, then the entire Personal Accident cover shall terminate for that Insured Person
v. In case of Permanent Disablement claims, the Company's maximum liability in a particular Policy Year shall never exceed the Sum Insured stipulated against Personal Accident cover
vi. Incase a claim is paid during the Policy Year under Permanent Disablement cover the Sum Insured for the same shall be replenished post completion of that Policy Year.
vii. In case we have paid a claim for a particular Permanent Disablement, we shall not be liable to pay future PD claims pertaining to the exact same claim in the lifetime of the Policy.
viii. In case we have paid a claim for Permanent Disablement during a Policy Year and the Insured person unfortunately succumbs to an Accidental Death in the same Policy Year, only the remaining portion of the Sum Insured (if any) stipulated against Personal Accident cover shall be payable as part of the Accidental Death cover.
ix. Geography of Personal Accident cover is worldwide
x. No waiting periods whatsoever shall apply to this cover

3. CRITICAL ILLNESS (BENEFIT BASED)

We will pay in Lumpsum the **Sum Insured** as specified in the **Policy Schedule**/Certificate of Insurance against this Cover, if an **Insured Person** suffers from any of the below listed **Critical Illnesses** during the **Policy Period**.

Specific Conditions applicable to Critical Illness (Benefit Based)

a. Waiting Period – The coverage is subject to a waiting period of 90 days from the date of inception of this cover with us. This Waiting Period shall not apply afresh at renewals. No other waiting period is applicable for claims under this cover.
b. **Survival Period** - The **Insured Person** must survive at least 30 days following such diagnosis.
c. Claim under this coverage shall be payable only if First diagnosis of the listed Critical Illness occurs after the applicable waiting period.

d. Incase a claim is paid during the Policy Year under this cover the coverage shall be replenished post completion of the Policy Year.
e. In case we have paid a claim for a particular listed Critical Illness, we shall not be liable to pay future claims under this benefit for that particular Critical Illness, in the lifetime of the Policy.
f. This cover is offered only on Individual **Sum Insured** basis.
g. Geography of Critical Illness (Benefit Based) cover is worldwide

Critical Illnesses Covered			
1	Cancer of specified severity	7	Major Organ/Bone Marrow Transplant
2	Open Chest CABG	8	Stroke resulting in permanent symptoms
3	Myocardial Infarction((First Heart Attack of specific severity)	9	Multiple Sclerosis with Persisting Symptoms
4	Open Heart Replacement or Repair of Heart Valves	10	Permanent Paralysis of Limbs
5	Kidney Failure requiring regular dialysis	11	Motor Neuron Disease with Permanent Symptoms
6	Coma of Specified Severity	12	Major Head Trauma

4. HOME NURSING COVER

We shall indemnify Home Nursing charges on a per day basis upto the per day amount as specified in the Policy Schedule/Certificate of insurance for availing the medical services of a Qualified Nurse at Your residence during the Policy Year.

Specific Definition applicable to Home Nursing Cover

For the purpose of this benefit, the term 'Qualified Nurse' means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Specific Conditions applicable to Home Nursing Cover

a. The nurse must be employed in a Hospital/Service provider
b. The engagement of such Qualified Nurse must be certified as necessary by a Medical Practitioner
c. The Nursing service must relate directly to a hospitalization admissible under the Policy.
d. The maximum number of days in a Policy Year upto which the per day coverage amount would be payable shall be as specified in the Policy Schedule/Certificate of insurance
e. All Waiting Periods as specified in the **Policy Schedule/**Certificate of Insurance against this cover shall apply. Timeframe for these waiting periods shall be as specified against this cover in the **Policy Schedule /** Certificate of Insurance. Terms, conditions and clauses for the applicable waiting periods are provided under Section 3.A.

5. LOSS OF INCOME DUE TO TEMPORARY TOTAL DISABLEMENT (INJURY ONLY)

If the Insured person sustains an Injury during the Policy Year, which is the sole and direct cause of a Temporary Total Disablement, we will pay the weekly benefit amount as specified against this Section in the Policy Schedule / Certificate of Insurance

Specific Conditions applicable to Loss of Income due to Temporary Total Disablement (Injury only)

a. The Temporary Total Disablement (TTD) sustained must be resultant from an Injury only
b. We will pay the weekly benefit amount only upto the maximum number of weeks as specified in the Policy Schedule / Certificate of Insurance
c. The per week Sum Insured stipulated in the Policy Schedule / Certificate of Insurance only denotes our maximum liability under this cover. However, at the time of claim, we will not pay any amount in excess of the Insured Person's base weekly income net of tax and other deductions, excluding overtime, bonuses, tips, commissions, or any other special compensation. Furthermore, only income emanating from a valid employment or occupation shall be considered.
d. The Temporary Total Disablement (TTD) must be confirmed by the attending Medical Practitioner
e. The TTD must completely prevent the Insured Person from performing each and every duty pertaining to his employment or occupation. Also, the time period of absenteeism from work should emanate from the diagnosed TTD and the same must be advised by the attending Medical Practitioner.
f. Claim under this benefit shall be admissible only if the Insured Person was actively engaged in his occupation or was employed at the time of diagnosis of TTD
g. The weekly benefit payable shall be calculated from the date of commencement of Temporary Total Disablement and will be paid only for duration that the Insured Person is deemed to be suffering from TTD.

h. The duration of the TTD shall be determined by the treating Medical Practitioner. He shall certify the date upon which the Insured person recovered from the TTD and was fit to perform his / her employment duties. The same must be in agreement with Us and be authorised by Us, for the benefit to become payable.
i. In case the TTD is for a period of less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.
j. This benefit shall be not be paid for the period of Time Deductible mentioned in Your Policy Schedule/Certificate of Insurance
k. The total benefit payout for a specific TTD shall not exceed product of the weekly benefit amount and the maximum number of weeks as specified against this Section in the Policy Schedule / Certificate of Insurance
l. No waiting periods whatsoever shall apply to this cover.
m. Geography of this benefit is Worldwide.

6. LOSS OF INCOME DUE TO TEMPORARY TOTAL DISABLEMENT (ILLNESS ONLY)

If the Insured person contracts an Illness during the Policy Year, which is the sole and direct cause of a Temporary Total Disablement, we will pay the weekly benefit amount as specified against this Section in the Policy Schedule / Certificate of Insurance

Specific Conditions applicable to Loss of Income due to Temporary Total Disablement (Illness only)

a. The Temporary Total Disablement (TTD) sustained must be resultant from an Illness only
b. We will pay the weekly benefit amount only upto the maximum number of weeks as specified in the Policy Schedule / Certificate of Insurance
c. The per week Sum Insured stipulated in the Policy Schedule / Certificate of Insurance only denotes our maximum liability under this cover. However, at the time of claim, we will not pay any amount in excess of the Insured Person's base weekly income net of tax and other deductions, excluding overtime, bonuses, tips, commissions, or any other special compensation. Furthermore, only income emanating from a valid employment or occupation shall be considered.
d. The Temporary Total Disablement (TTD) must be confirmed by the attending Medical Practitioner
e. The TTD must completely prevent the Insured Person from performing each and every duty pertaining to his employment or occupation. Also, time period of absenteeism from work should emanate from the diagnosed TTD and the same must be advised by the attending Medical Practitioner.
f. Claim under this benefit shall be admissible only if the Insured Person was actively engaged in his occupation or was employed at the time of diagnosis of TTD
g. The weekly benefit payable shall be calculated from the date of commencement of Temporary Total Disablement and will be paid only for duration that the Insured Person is deemed to be suffering from TTD.
h. The duration of the TTD shall be determined by the treating Medical Practitioner. He shall certify the date upon which the Insured person recovered from the TTD and was fit to perform his / her employment duties. The same must be in agreement with Us and be authorised by Us, for the benefit to become payable.
i. In case the TTD is for a period of less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.
j. This benefit shall be not be paid for the period of Time Deductible mentioned in Your Policy Schedule/Certificate of Insurance
k. The total benefit payout for a specific TTD shall not exceed product of the weekly benefit amount and the maximum number of weeks as specified against this Section in the Policy Schedule / Certificate of Insurance.

l. All Waiting Periods as specified in the **Policy Schedule/**Certificate of Insurance against this cover shall apply. Timeframe for these waiting periods shall be as specified against this cover in the **Policy Schedule /** Certificate of Insurance. Terms, conditions and clauses for the applicable waiting periods are provided under Section 3.A.
m. Geography of this benefit is Worldwide.

7. LOSS OF INCOME DUE TO TEMPORARY TOTAL DISABLEMENT (ILLNESS AND INJURY)

If the Insured person contracts an Illness or sustains an Injury during the Policy Year, which is the sole and direct cause of a Temporary Total Disablement, we will pay the weekly benefit amount as specified against this Section, in the Policy Schedule / Certificate of Insurance

Specific Conditions applicable to Loss of Income due to Temporary Total Disablement (Illness and Injury)

a. The Temporary Total Disablement (TTD) must be confirmed by the attending Medical Practitioner
b. We will pay the weekly benefit amount only upto the maximum number of weeks as specified in the Policy Schedule / Certificate of Insurance
c. The per week Sum Insured stipulated in the Policy Schedule / Certificate of Insurance only denotes our maximum liability under this cover. However, at the time of claim, we will not pay any amount in excess of the Insured Person's base weekly income net of tax and other deductions, excluding overtime, bonuses, tips, commissions, or any other special compensation. Furthermore, only income emanating from a valid employment or occupation shall be considered.
d. The TTD must completely prevent the Insured Person from performing each and every duty pertaining to his employment or occupation. Also, time period of absenteeism from work should emanate from the diagnosed TTD and the same must be advised by the attending Medical Practitioner.
e. Claim under this benefit shall be admissible only if the Insured Person was actively engaged in his occupation or was employed at the time of diagnosis of TTD
f. The weekly benefit payable shall be calculated from the date of commencement of Temporary Total Disablement and will be paid only for duration that the Insured Person is deemed to be suffering from TTD.
g. The duration of the TTD shall be determined by the treating Medical Practitioner. He shall certify the date upon which the Insured person recovered from the TTD and was fit to perform his / her employment duties. The same must be in agreement with Us and be authorised by Us, for the benefit to become payable.
h. In case the TTD is for a period of less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.
i. This benefit shall be not be paid for the period of Time Deductible mentioned in Your Policy Schedule/Certificate of Insurance
j. The total benefit payout for a specific TTD shall not exceed product of the weekly benefit amount and the maximum number of weeks as specified against this Section in the Policy Schedule / Certificate of Insurance
k. No waiting periods whatsoever shall apply to this cover only for claims arising due to an Injury
l. All Waiting Periods as specified in the **Policy Schedule/**Certificate of Insurance against this cover shall apply only for claims pertaining to Illnesses. Timeframe for these waiting periods shall be as specified against this cover in the **Policy Schedule /** Certificate of Insurance. Terms, conditions and clauses for the applicable waiting periods are provided under Section 3.A. No waiting periods shall apply to Injury related claims.
m. Geography of this benefit is Worldwide.

8. VECTOR BORNE DISEASE COVER (INDEMNITY)

In the event that an Insured Person undergoes Medically Necessary Hospitalization for the disease plan as opted & mentioned in the Policy Schedule / Certificate of Insurance, we will indemnify the below mentioned medical expenses upto the Sum Insured stipulated against this cover.

Waiting Period – This coverage is subject to a waiting period of 30 days (unless specified otherwise in the Policy Schedule / Certificate of Insurance against this cover) from the date of inception of this cover with us. This Waiting Period shall not apply afresh at renewals.No other waiting period is applicable for claims under this cover.
The medical expenses payable shall be as listed below and should be incurred during the Policy Year

For diease plan related details kindly refer Annexure 3

I. Medical expenses

a. In-Patient Hospitalization Expenses

i. Room rent, boarding and Nursing charges restricted to Single Standard AC Room
ii. Intensive Care Unit charges
iii. Consultation fees
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
v. Medicines, drugs and consumables
vi. Diagnostic procedures

Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-Patient Hospitalization Expenses' cover if undertaken in an AYUSH Hospital. However, any medical expense other than In-patient care AYUSH treatment expenses are not covered under VECTOR BORNE DISEASE COVER (INDEMNITY).

Proportionate Deduction

Room Rent & Proportionate deduction: Insured Person is eligible for **Room Rent** category of up to Single Standard AC Room. In case of admission to a room exceeding the aforesaid category, the reimbursement/payment of Room Rent charges including all **Associated Medical Expenses** incurred at Hospital shall be affected 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.

b. Health Care at Home

Under this cover, The Company shall indemnify the Medical Expenses incurred by the Insured Person on availing treatment for the opted illness at Home during the Policy Year

Specific Conditions applicable to Health Care at Home

i. Home Healthcare treatment must be prescribed in writing by the treating Medical Practitioner.
ii. The treatment must be such that in normal course it would have required In-patient Care at a Hospital, and a claim would have been admissible In-Patient Hospitalization Expenses benefit above.
iii. The treatment must be pre-authorized by Us as per procedure given as under
iv. Records of the treatment administered, duly signed by the treating Medical Practitioner, must be maintained for each day of the Home treatment.
v. This Cover is not available on reimbursement basis.

Specific Claim procedure applicable to Health Care at Home

a. Notification of Claim

Notice with full particulars must be sent to the Company at least 48 hours prior to availing treatment under Health Care at Home

b. Procedure for Cashless Claims

i. On receipt of duly filled pre authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company.

ii. On receipt of the complete documents, the Company may:

- Issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, OR
- Reject the request for pre-authorization specifying reasons for the rejection.

c. Pre and Post Hospitalization Cover

If we have accepted a claim under ***In-Patient Hospitalization Expenses,*** w**e** will pay for the **Pre-Hospitalization Medical Expenses** incurred during the 15 days immediately prior to the **Hospitalization** of the **Insured Person.**

Also if we have accepted a claim under ***In-Patient Hospitalization Expenses,*** w**e** will pay for the **Post-Hospitalization Medical Expenses** incurred during the 30 days immediately post discharge of the **Insured Person.**

d. Reinstatement of Sum Insured

We will add to the Sum Insured, an amount equivalent to the Claim amount paid under this benefit during the Policy Year. This reinstated amount will be available for subsequent hospitalization claims that may arise during the remainder of the Policy Year.

Specific Conditions applicable to Reinstatement of Sum Insured

i. Any unutilized portion of the reinstated Sum Insured shall NOT be carried over to next policy year

ii. Maximum reinstatement of Sum Insured in any given Policy Year shall never exceed the Sum Insured of Vector Borne Disease Cover (Indemnity)

iii. The reinstated Sum Insured can only be used to pay for medical expenses incurred under In-Patient Hospitalization Expenses, Health Care at Home and Pre and Post Hospitalization Cover

iv. Reinstatement shall not be applicable for hospitalization under Any One Illness

II. Optional covers under Vector Borne Disease Cover (Indemnity)

a. Outpatient Treatment Expenses

We will indemnify the Insured Person the below mentioned expenses incurred on Medically Necessary treatment for the disease as opted & mention in the Policy Schedule / Certificate of Insurance;

i. Outpatient Consultation with Medical Practitioner

ii. Diagnostic Tests

iii. Pharmacy

Specific Conditions applicable to Outpatient Treatment Expenses

i. Indemnification of above mentioned expenses shall be upto an additional Sum Insured of INR 5,000

ii. If a Claim is payable under Outpatient Treatment Expenses and if the Insured Person is subsequently hospitalized within 15 days for the Medically Necessary treatment of same illness, then the entire Claim shall be admissible under **In-Patient Hospitalization Expenses and Pre and Post Hospitalization Cover** only and shall be payable from the Sum Insured of Vector Borne Disease Cover (Indemnity).

b. Recovery Benefit

We shall pay INR 20,000 additionally in Lumpsum if an Insured Person is hospitalized for a period of more than 10 consecutive and continuous days, for the disease as opted & mentioned in the Policy Schedule / Certificate of Insurance.

Specific Conditions applicable to Recovery Benefit

This benefit shall not be payable if Medical treatment is taken under Health Care at Home

c. Co-payment

Co-Payment as opted under this particular cover and mentioned in the Policy Schedule / Certificate of Insurance will be applied on each and every admissible claim under Vector Borne Disease Cover (Indemnity) cover

d. Waiting Period Modification Options

On availing this option, Waiting Period for Vector Borne Disease Cover (Indemnity) Section will be modified and shall be applicable as mentioned on the Policy Schedule/Certificate of Insurance

9. VECTOR BORNE DISEASE COVER (FIXED BENEFIT)

In the event that an Insured Person undergoes Medically Necessary Hospitalization (including In-patient care AYUSH Treatment in an AYUSH Hospital) in excess of the Time Deductible opted, for the disease plan mentioned in the Policy Schedule / Certificate of Insurance, we shall pay in Lumpsum the amount stipulated against this Section in the Policy Schedule / Certificate of Insurance.

The Medically Necessary Hospitalization should fall during the Policy Year

Waiting Period – This coverage is subject to a waiting period of 30 days (unless specified otherwise in the Policy Schedule / Certificate of Insurance against this cover) from the date of inception of this cover with us. This Waiting Period shall not apply afresh at renewals. No other waiting period is applicable for claims under this cover.
For diease plan related details kindly refer Annexure 3

Reinstatement of Sum Insured

In case of an admissible claim under Vector Borne Disease Cover (Fixed Benefit), 100% of the Sum Insured shall be instantly added only once in the Policy Year for any subsequent claims that may arise during the remainder of the Policy Year under this cover. Any unutilized reinstated Sum Insured shall NOT be carried over to next policy year. Reinstatement shall not be applicable for hospitalization under Any One Illness

I. Optional covers under Vector Borne Disease Cover (Fixed Benefit)

a. Outpatient Treatment Expenses

We will additionally pay in Lumpsum 50% of the Sum Insured, subject to a maximum of INR 5000 towards expenses incurred on;

i. Outpatient Consultationwith Medical Practitioner

ii. Diagnostic Tests

iii. Pharmacy

Specific Conditions applicable to Outpatient Treatment Expenses

i. This benefit has a separate additional Sum Insured which shall be 50% of the Sum Insured of Vector Borne Disease Cover (Fixed Benefit), subject to maximum of INR 5,000

ii. If a Claim is payable under Outpatient Treatment Expenses and if the Insured Person is subsequently hospitalized within 15 days for the Medically Necessary treatment of same illness, then the entire Claim shall be payable from the Base Sum Insured of Vector Borne Disease Cover (Fixed Benefit) and no additional payout shall be made under this optional cover.

b. Recovery Benefit

We shall pay INR 20,000 additionally in Lumpsum if an Insured Person is hospitalized for a period of more than 10 consecutive and continuous days, for the disease as opted & mentioned in the Policy Schedule / Certificate of Insurance.

c. Waiting Period Modification Options

On availing this option, Waiting Period for Vector Borne Disease Cover (Fixed Benefit) Section will be modified and shall be applicable as mentioned on the Policy Schedule/Certificate of Insurance

10. VECTOR BORNE DISEASE COVER (PER DAY BENEFIT)

In the event that an Insured Person undergoes Medically Necessary Hospitalization (including In-patient care AYUSH Treatment in an AYUSH Hospital) for the disease plan mentioned in the Policy Schedule / Certificate of Insurance, we shall pay the per day Benefit as stipulated against this Section in the Policy Schedule / Certificate of Insurance for each continuous and completed day of Hospitalization.

The Medically Necessary Hospitalization should fall during the Policy Year

Waiting Period – This coverage is subject to a waiting period of 30 days (unless specified otherwise in the Policy Schedule / Certificate of Insurance against this cover) from the date of inception of this cover with us. This Waiting Period shall not apply afresh at renewals. No other waiting period is applicable for claims under this cover.
For diease plan related details kindly refer Annexure 3

Specific Conditions applicable to Vector Borne Disease Cover (per day Benefit)

a. The per day hospitalization amount shall be paid upto the maximum number of days for a given Policy Year as stipulated against this Section in the Policy Schedule / Certificate of Insurance.

b. The per day hospitalization amount shall be paid in excess of the Time Deductible opted and mentioned against this Section in the Policy Schedule / Certificate of Insurance.

I. Optional covers under Vector Borne Disease Cover (per day Benefit)

a. Recovery Benefit

We shall pay INR 20,000 additionally in Lumpsum if an Insured Person is hospitalized for a period of more than 10 consecutive and continuous days, for the disease as opted & mentioned in the Policy Schedule / Certificate of Insurance.

b. Waiting Period Modification Options

On availing this option, Waiting Period for Vector Borne Disease Cover (Fixed Benefit) Section will be modified and shall be applicable as mentioned on the Policy Schedule/Certificate of Insurance

c. ICU Multiplier

We will pay a multiple of the opted per day benefit **Sum Insured** as specified on the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of **Hospitalization** of **Insured Person** in the **Intensive Care Unit**.

Specific Conditions applicable to ICU Multiplier

On days wherein the Insured person is hospitalized in the ICU, normal room per day benefit payout shall not be made.

SECTION 3 - EXCLUSIONS AND WAITING PERIODS

A. WAITING PERIODS

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

We will not make payment for any claim in respect of any **Insured Person** attributable to any of the following unless expressly stated to the contrary in the **Policy Schedule / Certificate of Insurance**

The below mentioned waiting periods shall apply only to Section 2.A.I and 2.A.II.

Waiting periods applicable to coverages under Section 2.B. shall be applicable as stated within the clauses of the coverage and as specified in the Policy Schedule / Certificate of Insurance

I. PRE-EXISTING DISEASES – CODE – EXCL01

a) Expenses related to the treatment of a **pre-existing disease** (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of sum of **Sum Insured** increase.
c) If the **Insured Person** is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the **Policy** after the expiry of 36 months for any **pre-existing disease** is subject to the same being declared at the time of application and accepted by Insurer.

II. SPECIFIED DISEASE / PROCEDURE WAITING PERIOD - CODE – EXCL02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident**.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of **Sum Insured** increase.
c) If any of the specified disease/procedure falls under the waiting period specified for **Pre-existing diseases**, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e) If the **Insured Person** is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

Illnesses

Non infective Arthritis	Pilonidal sinus

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

Surgical Procedures

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

III. 30-DAY WAITING PERIOD – CODE – EXCL03

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

B. EXCLUSIONS

The exclusions listed below are applicable for all sections and all coverages of the Policy unless expressly stated otherwise in the coverage itself. These exclusions are in addition to the Specific Exclusion stated explicitly under certain benefits.

I. STANDARD 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**:

1. **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.
2. **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.
3. **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:
         a) Obesity related cardiomyopathy
         b) coronary heart disease
         c) severe sleep apnoea
         d) uncontrolled type2 diabetes
4. **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.
5. **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.**
6. **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.

7. **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.
8. **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.
9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12
10. 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
11. 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
12. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15
13. **Unproven Treatments–** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.Code – Excl16
14. **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
15. **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.

II. SPECIFIC PERMANENT EXCLUSIONS

1. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, **Nuclear**, **Chemical** or **Biological** attack or weapons, radiation of any kind.
2. Aggregate Deductible - We are not liable for Claims/Claim amount falling within **Aggregate Deductible** limit if opted and as mentioned on the Schedule of Coverage in the **PolicySchedule**/Certificate of Insurance.
3. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide.
4. Any **Insured Person**'s participation or involvement in naval, military or air force operation.
5. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
6. Congenital external diseases, defects or anomalies,
7. Stem cell harvesting.
8. Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
9. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).
10. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
11. Vaccination including inoculation and immunisations (Except post Animal bite treatment),
12. **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 in Annexure 1 and also available at www.hdfcergo.com.
13. OPD treatment
14. The provision or fitting of hearing aids, spectacles or contact lenses.
15. 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.
16. 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.
17. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses is attached in Annexure 1 and also available on www.hdfcergo.com
18. Any Medical treatment or hospitalization availed outside India
19. Dental treatment and surgery of any kind, unless requiring Hospitalisation
20. Any non allopathic treatment unless explicitly specified under a benefit/coverage in this Policy. Exclusion shall be superceeded on to the extent of coverage provided under such benefit/coverage.
21. Prosthetic and other devices which are self- detachable /removable without surgery involving anaesthesia.
22. Treatment at a healthcare facility which is NOT a Hospital

23. 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.
24. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

SECTION 3 – GENERAL TERMS AND CLAUSES

A. STANDARD GENERAL TERMS AND CLAUSES

1. Disclosure of Information

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

2. Condition Precedent to Admission of Liability

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

3. Complete Discharge

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

4. Multiple Policies

i. In case of multiple policies taken by an **InsuredPerson** during a period from one or more insurers to indemnify treatment costs, the **InsuredPerson** shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the **Insurer** chosen by the **Insured Person** shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen **Policy**.
ii. **Insured Person** having multiple policies shall also have the right to prefer claims under this **Policy** for the amounts disallowed under any other **Policy** / policies even if the sum insured is not exhausted. Then the **Insurer** shall independently settle the claim subject to the terms and conditions of this **Policy**.
iii. If the amount to be claimed exceeds the **Sum Insured** under a single **Policy**, the **InsuredPerson**shall have the right to choose **Insurer** from whom he/she wants to claim the balance amount.
iv. Where an **Insured Person** has policies from more than one **Insurer** to cover the same risk on indemnity basis, the **Insured Person** shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen **Policy**.

5. Moratorium Period

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

6. 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**.

7. Free look period

Not Applicable on Group Health Products

8. Migration

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

For Detailed Guidelines on Migration, kindly refer the link

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

9. 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

10. Cancellation

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

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

b. 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.

c. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s

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

11. 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. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of Non-Instalment Premium Payment, coverage shall not be available for the period for which no premium is received).

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**.

12. Instalment premium payment through Auto Debit/ECS Facility

i. If Option of Premium payment by instalment is opted through auto Debit/ECS facility, Electronic Clearing Service (ECS) Mandate form needs to be completely filled & signed by the Insured Person.
ii. The Premium amount which would be auto debited & frequency of instalment should be duly filled in the ECS Mandate form.
iii. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
iv. The Company should be informed at least 15 days prior to the due date of instalment premium if the Insured Person wishes to discontinue the ECS facility.
v. Non-payment of premium on due date as opted by the Insured Person in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

13. 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.

14. Withdrawal of Policy

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

15. Nomination

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

16. Claim Settlement (provision for Penal Interest)

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

17. Renewal of Policy:

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

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

18. Redressal of Grievance

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

- Website: www.hdfcergo.com
- Customer Service No: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/

B. SPECIFIC TERMS AND CLAUSES

1. Non - Disclosure or Misrepresentation

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

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

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

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

a) Permanently exclude the disease/condition and continue with the **Policy**
b) Incorporate additional waiting period of not exceeding 3 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.

2. Geography

All coverages and sections under this Policy cover medical expenses and/or hospitalizations availed in India only, unless expilcitly specified otherwise within the Coverage details of any Section / Benefit.

3. Loadings

i. **We** may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.
ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each **Insured Person**
iii. Loadings will be applied from Commencement date of the **Policy** including subsequent **Renewal**(s) with **Us** or on increased **Sum Insured**. We will not apply any additional loading on **Your Policy** premium at **Renewal** based on claim experience in **Your Policy**.
iv. **We** will inform **You** about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the **Policy** only on **Your** acceptance within 15 days of the receipt of such counter offer letter. In case, **You** neither accept the counter offer nor revert to **Us** within 15 days, **We** shall cancel **Your** application and refund the premium paid within next 7 days.

4. 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.
iv. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Instalment Premium Option	Grace Period applicable
Half Yearly	30 days

Quarterly	30 days
Monthly	15 days

5. Endorsements

The following endorsements are permissible during the **Policy Period**:

Non-Financial Endorsements – which do not affect the premium

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

Financial Endorsements – which result in alteration in premium

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

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

6. 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**.

7. Utilization of Sum Insured

Utilization of Sum Insured, for indemnification of expenses incurred as a result of hospitalization shall follow the progressive order as specified below if the same is inforce, applicable and available:

vii. Room Rent eligibility

viii. Annual Aggregate deductible

ix. Co-payment

x. Sum insured / Sub-limit OR Capping of that coverage/sub-coverage

xi. Double Sum Insured for Critical Illness

xii. Cumulative bonus

xiii. Inflation Protector

xiv. Secure Benefit

xv. Restore benefit

xvi. Double Restore benefit OR Unlimited Restore Benefit

8. Single Claim in a Policy Year [Applicable to Section 2.A.I and 2.A.II. only]

Our maximum liability for a single claim in any given Policy Year shall never exceed the cumulative addition of the below mentioned covers

i. Base Sum Insured (as opted and as whole in amount terms)

ii. Double Sum Insured for Critical Illness (if in force & remaining)

iii. Cumulative bonus (if in force & remaining)

iv. Inflation Protector (if in force & remaining)

v. Secure Benefit (if in force & remaining)

9. Splitting of Family Floater policies

When a dependent child attains the age of 25 years, he or she shall be ineligible for coverage in the subsequent renewals and will be migrated to a new Policy, with continuity benefits.

10. Credit Linkage of Policy

a. This Policy can be credit linked to a specific loan. Such loan details shall be provided at the time of enrolment.

11.Assignment Clause (Applicable only for Credit linked Policies)

For credit linked Policies it is hereby declared and agreed that:

a. From the Policy Start Date,the monies payable by the Company to the Insured and all rights, title, benefits and interest of the Insured for Sections as opted stands assigned in favour of the “Bank / Financial institution“ as named in the Policy Schedule of this Policy.
b. Upon any monies becoming payable under this Policy the same shall be paid by the Company to the “ Bank / Financial institution“ as named in Schedule of this Policy without any reference / notice to the Insured , but not exceeding the Principal Out standing as defined under the Policy . In the event of any monies payable under this Policy exceeding the Principal Out standing , the Company shall pay such monies as exceeding the Principal Outstanding to the Insured/Nominee.
c. The receipt of such monies in the manner aforesaid by the Bank/Financial Institution as named in the Schedule of this Policy and the Insured shall completely discharge the Company from all liability under the Policy and shall be binding on the Insured and the

heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

d. That any adjustment, settlement, compromise or reference to arbitration in connection with any dispute between the Company and the insured or any of them arising under or in connection with this policy if made by the Financier shall be valid and binding on all parties insured here under but not so as to impair right of the Financier to recover the full amount of any claim it may have on other parties insured here under but not so as to impair.

e. The benefits under this Policy are assignable subject to applicable Laws.

C. OTHER TERMS AND CONDITIONS

I. 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
Claim Intimation Timelines for Critical Illness related claims	Within 15 days of the diagnosis of Critical Illness or Hospitalization		
Particulars to be provided to us for claim notification	1. The health card issued by Us 2. KYC documents 3. The Policy Number 4. Name of the Policyholder 5. Name and address of Insured Person in respect of whom the request is being made 6. Nature of the Illness/Injury and the treatment/Surgery required 7. Name and address of the attending Medical Practitioner 8. Hospital where treatment/Surgery is proposed to be taken or /Hospital where the Insured person is admitted 9. Proposed /Actual Date of admission 10. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.		

Claims documents to be submitted for Hospital Cash	1. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for **Hospital** cash benefit 2. First consultation letter from treating **Medical Practitioner** 3. Certificate from treating Medical Practitioner, specifying the duration and aetiology 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
Claims Documents to be submitted for Critical Illness related claims	1. Copy of Discharge Summary / Discharge Certificate / Death Certificate (in case insured expired); 2. First consultation letter from treating Medical Practitioner 3. Medical certificate confirming diagnosis, and the treatment from Medical Practitioner 4. certificate from treating Medical Practitioner, specifying the duration and etiology 5. OT Notes in case of Surgery 6. Medical certificate from treating Medical Practitioner specifying the diagnosis and need for the surgery 7. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 8. All pathological/Histopathological and radiological Investigation Reports 9. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor. Provide KYC (Know your customer) form along with photocopy of any one of following KYC documents for all claims amounting to Rs 1 lakh and above (Aadhaar Card, Passport, Driving License Voter ID, etc) We may require the Insured Person to undergo medical examination by Medical Practitioner authorized by Us to obtain an independent medical opinion for the processing of the claim. Any cost towards such medical examination will be borne by Us.
Claims documents and procedure for Second Medical Opinion	1. Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) 2. Select **Our** network **Medical Practitioner** from whom you would prefer to take the second opinion. (Please refer our Website or call us at our customer service number to obtain the list of **Our** panel doctors). 3. On receipt of the complete set of documents, We will forward the same to the concerned doctor. 4. The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.

Claims documents to be submitted for cases of Accidental Death	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Death certificate 4. Post mortem if conducted/FSL (Forensic science laboratory)report – To check for drug abuse/intoxication 5. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable	
Claims documents to be submitted for cases of Permanent Disablement	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the **Injury**; 4. Disability certificate from a government certified **Medical Practitioner** or government **Hospital** confirming the extent and nature of disability; 5. Discharge summary from the **Hospital** Medical reports, case histories, investigation reports,treatmentpapers as applicable. 6. Letter from treating **Medical Practitioner** mentioning the reason and date for disablement and confirming the disablement. 7. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable	
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the **Insured person**(s) iii. Nature of disease/**Illness/Injury** iv. Name and address of the attending**Medical Practitioner/Hospital** v. Date of admission & probable date of discharge vi. Approximate Claim Expenses vii. 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.	

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

2. List of documents for Reimbursement Claims

i. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by **Hospital**).
ii. Government approved Photo ID & Age Proof
iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of **Hospitalization** in any non-network hospital of HDFC ERGO General Insurance 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 - (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.
xx. Written adivice from the treating Medical Practitioner (wherever required)
xxi. Loan account details and bank statements (wherever required)

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

3. Conditions for obtaining Cashless facility

i. **Cashless facility** can be availed only at **Our Network Provider**. The complete list of **Network Providers** and empanelled Service Providers is available on **Our** website and can be obtained by contacting **Us**.
ii. We reserve the right to modify, add or restrict any **Network Provider** for Cashless Facilities at **Our** sole discretion. The same shall be duly updated on **Our** website. **You** shall check the updated list of **Network Providers** before applying for Cashless Claim.
iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the **Hospitalization**/treatment, including dates**, Hospital** and locations match with the details as per Cashless authorized.
iv. **We** will make payment for the Cashless authorized amount directly to the **Network Provider**.

v. If the claim is not notified to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, **We** will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents

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

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

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

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

vi. If **We**, for any reason decide to reject the claim, the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.

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

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

II. Contact Us

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

- Website : www.hdfcergo.com
- Claim Intimation : healthclaims@hdfcergo.com
- Customer Service No. 022-62346234 / 0120- 62346234
- Courier : Claims Department,
  HDFC ERGO General Insurance Co. Ltd.
  Stellar IT Park, Tower-1
  5th Floor, C - 25, Sector 62
  Noida – 0120 398 8360

OMBUDSMAN DETAILS

S.No	Office Details	Jurisdiction of Office (Union Territory,District)
1	**AHMEDABAD** Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
2	**BENGALURU** Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
3	**BHOPAL** Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202: bimalokpal. Email bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.

4	**BHUBANESWAR** Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
5	**CHANDIGARH** Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
6	**CHENNAI** Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
7	**DELHI** Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

8	**GUWAHATI** Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Shri N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
10	**JAIPUR** Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
11	**KOCHI** Shri G. Radhakrishnan Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
12	**KOLKATA** Ms Kiran Sahdev Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.

13	**LUCKNOW** Shri. Atul Sahai Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	**MUMBAI** Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
15	**NOIDA** Shri Bimbadhar Pradhan Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

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

ANNEXURES

ANNEXURE 1

LIST I – ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR

9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY

LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

LIST III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES

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

LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT

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

ANNEXURE 2

Section No.	Name of Cover
Section 2.A.I. - Hospitalization Expenses	Section 2.A.I.a. – Medical Expenses Section 2.A.I.b. – Pre-Hospitalization Medical Expenses Cover Section 2.A.I.c. – Pre-Hospitalization Medical Expenses Cover Section 2.A.I.d – Domiciliary Hospitalization (if in force) Section 2.A.I.e. – Organ Donor Expenses Section 2.A.I.f. – Day Care procedures Section 2.A.I.g. – Road Ambulance Cover (if in force)
Section 2.A.II.8.	Alternative Treatment (if in force)
Section 2.A.II.13.	Maternity Cover (if in force)
Section 2.A.II.14.	Pre and Post Natal Expenses (if in force)
Section 2.A.II.15.	Baby Cover from Day 1 (if in force)
Section 2.A.II.16.	Infertility Cover (if in force)
Section 2.A.II.25.	Home Healthcare (if in force)
Section 2.A.II.28.	Protect Benefit (if in force)

ANNEXURE 3

Plan A
Dengue Only

Plan B
Malaria Only

Plan C
Dengue
Malaria
Chikungunya
Japanese Encephalitis
Kala Azar
Lymphatic Filariasis
Zika

Only one plan from amongst Plan A, B, C can be opted