HDFC ERGO General Insurance Company Limited

Policy Wordings

Group Assurance Health Plan

HDFC ERGO General Insurance Ltd.willcover all the Insured Persons under this Policy upto the Sum Insured. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

Section A. Definitions

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

I. Standard Definitions

Def 1. **Accident** means 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 with in-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. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

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

a) **Internal Congenital Anomaly**

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 7. **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 8. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def 9. **Critical Illness** means any one of the following illnesses or conditions that occurs or manifests itself

PWW/Ver - 1 AUG2021

during the Policy Period as a first incidence and the insured survives the defined survival period

a) Cancer of specified severity

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

II. The following are excluded –

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

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

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

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

v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi) Chronic lymphocytic leukaemia less than RAI stage 3

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

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

b) 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:

(i) Angioplasty and/or any other intra-arterial procedures

c) Myocardial Infarction (First heart attack of specific 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:

i) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii) New characteristic electrocardiogram changes

iii) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i) Other acute Coronary Syndromes

ii) Any type of angina pectoris

iii) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

d) 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.

e) Major Organ/Bone Marrow Transplant

I. The actual undergoing of a transplant of:

i) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii) Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i) Other stem-cell transplants

ii) Where only islets of langerhans are transplanted

f) Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i) investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii) 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.

g) 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.

h) Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. 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:

i) Transient ischemic attacks (TIA)

ii) Traumatic injury of the brain

iii) Vascular disease affecting only the eye or optic nerve or vestibular functions.

i) 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 disease affected 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.

j) **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 forat 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.

k) 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 primarylateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbarefferent 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.

l) 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;

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 a fully equipped operation theatre of its

own where surgical procedures are carried out

iv) maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

Def 11. **Day Care Treatment** means medical treatment, and/ or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and

ii. which would have otherwise required a hospitalisation of more than twenty four 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 teethincluding examinations, fillings (where appropriate), crowns, extractions and surgery.

Def 13. **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 14. Disclosure to information norms means that the Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def 15. Domiciliary Hospitalisation means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

iii) the condition of the patient is such that he/ she is not in a condition to be removed to a hospital, or

iv) the patient takes treatment at home on account of non-availability of room in a hospital.

Def 16. Emergency Caremeans 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 17. **Grace Period** means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not 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 disease/ 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 Schedule/Certificate of Insurance of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

v) has qualified nursing staff under its employment round the clock;

vi) has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;

vii) has qualified medical practitioner (s) in charge round the clock;

Viii) has a fully equipped operation theatre of its own where surgical procedures are carried out

ix) maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

Def 19. **Hospitalisation or Hospitalised** 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** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itselfduring the policy period and requires medical treatment.

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

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

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 special 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 on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Def. 25. **Maternity Expenses** means

b) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during Hospitalization).

c) 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 doctors in the same locality would have charged for the same medical treatment.

Def 28. **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 29. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i) is required for the medical management of illness or injury suffered by the insured;

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 30. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def 31. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

Def. 32. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def 33. **Non- Network Provider** means any hospital that is not part of the network.

Def 34. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

Def 35. **OPD Treatment** means the one 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 36. **Portability** means the right accorded to an individual health insurance Policyholders (including all members under family cover) to transfer the credits gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

Def 37. **Pre-Existing Disease (PED)**: Pre existing disease means any condition, ailment, injury or disease

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

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

Def 38. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during the period of 30days preceding the hospitalisation of the Insured Person, provided that:

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

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

Def 39. **Post-hospitalisation Medical Expenses** means medical expenses incurred during the period of 60days 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 hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

Def 40. **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 41. **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.

Def. 42. **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 43. **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 44. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.

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 of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Def. 46. **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.

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. **Associated Medical Expenses** means cconsultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anaesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def.3 **Administrator** means any entity/person(s) engaged by the Insurer for providing Policy and claims facilitation services to the Insured as well as toUs.

Def. 4. **Age or Aged** means completed years as at the Commencement Date.

Def. 5. **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 6. **Bank rate** shall 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.7 **Cashless facility** means a facility extended by the insurer to the insured where thepayments, of the costs of treatment undergone by the insured in accordance with thePolicy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

Def. 8. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule/ Certificate of Insurance

Def. 9. **Dependents** means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;

ii) Your children Aged between 91 days and 25 years if they are unmarried

iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Group Assurance Health PlanInsurancePolicy.

iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Group Assurance Health Plan Insurance Policy.

v) All Dependent parents must be financially dependent on You.

Def.10 **Dependent Child** 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.11 **Family Floater** means a Policy described as such in the Schedule/Certificate of Insurance where under You and Your Dependents named in the Schedule/Certificate of Insurance are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def.12 **Insured Person** means You and the persons named in the Schedule/Certificate of Insurance.

Def.13 **Material Facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def.14 **Policy** means Your statements in the proposal form (which are the basis of this Policy), this Policy wording (including endorsements, if any) and the Policy Schedule (as the same may be amended from time to time).

Def.15 **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule/Certificate of Insurance.For Insured Person it means Period of Insurance as specified in the Certificate of Insurance or Endorsement.

Def.16 **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def.17 **Shared Accommodation** means hospitalisation in a Hospital room with two or more In-patient beds

Def.18 **Survival period** means the period after an insured event that the Insured Person has to survive before a claim is payable

Def.19 **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule/Certificate of Insurance.

Def.20 **We/Our/Us** means the HDFC ERGO General Insurance Limited.

Def.21 **You/Your/Policyholder** means the person named in the Schedule/Certificate of Insurance who has concluded this Policy with Us.

Important terms You should know

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

Inpatient care means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

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 its scope and jurisdiction of license.

Section B. Inpatient Benefit

This section of benefits is applicable when

- An Insured Personsuffers an Accident or Illness, which is covered under this Policy; AND
- Hospitalisation is necessary & is done for treatment OR
- Day care treatment is necessary and is done OR
- Domiciliary Hospitalization is necessary and is done for treatment

We will cover the Medical Expenses for:	**We will not cover treatment, costs or expenses for*:** *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section C.
a. In-patient Treatment. This includes • Hospital room rent or boarding • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	
b. Pre-Hospitalisation Pre-Hospitalization Medical Expenses for consultations, investigations and medicines incurred upto 30 daysbefore the date of admission to the Hospital This is applicable for In-patient treatment, Day Care treatment, or Domiciliary treatment.	ii) Claims which have NOT been admitted under 1 a),1d) and 1e) iii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.

c. Post-Hospitalisation Post Hospitalization Medical Expenses for consultations, investigations and medicines incurred upto 60 days after discharge from the Hospital.This is applicable for In-patienttreatment,Day Care treatment, or domiciliary treatment.	i) Claims which have NOT been admitted under 1 a),1 d) and 1e) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
d. Day Care Treatment: Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours because of technological advancement. Treatment normally taken on out-patient basis is not included in the scope of this definition.	i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) Treatment NOT taken at a Hospital or a Day Care centre.
e. Domiciliary Hospitalisation: Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii. The patient takes treatment at home on account of non-availability of room in a Hospital	i) Treatment of less than 3 days. ii) Expenses for treatment for first three days only will be covered if treatment period is greater than 3 days)
f. Organ Donor: Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an Insured Person while donating an organ is NOT covered.	i) Claims which have NOT been admitted under 1a) for the insured person. ii) Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). iii) The organ donor's Pre and Post-Hospitalisation expenses.
g. Ambulance Cover: Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to a maximum of Rs. 2000 per Hospitalisation.	i) Claims which have NOT been admitted under Section 1a) and 1d) ii) Healthcare or ambulance service provider not registered with road traffic authority.

Any claims made under the above mentioned benefit is subject to Inpatient Sum Insured

Section C. Waiting Period & Exclusions

A. Standard Waiting Period

All Illnesses, treatments and their associated complications shall be covered subject to the waiting periods specified below:

i) 30-day waiting period

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

b) This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii) Specified Disease/Procedure waiting period

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accidentor underlying cause is cancer(s).

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/migration stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures: -

Sl No.	Organ / Organ System	Illness/ diagnoses (irrespective of treatments medical or surgical)	Surgeries/ procedures (irrespective of any illness / diagnosis other than cancers)
a.	Ear, Nose and Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
b.	Gynaecological	• cysts, polyps including breast lumps • Polycystic ovarian disease • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
c.	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
d.	Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/ fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia
e.	Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	• Cataract • Retinal detachment • Glaucoma	• Nil
g.	Others	• Nil	• Surgery of varicose veins and varicose ulcers

h.	General (Applicable to all organ systems/organs whether or not described above)	• Benign tumors of Non infectious etiologye. eg. cysts, nodules, polyps, lump, growth, etc	• Nil

iii) Pre-Existing Diseases

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

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

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

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

Important terms You should know

Pre-existing Conditionmeans any condition, ailment, injury or disease:

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

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

B. Standard General Exclusions

We will not pay for any claim which is arising from the following, including their associated complications

Non Medical Exclusions	i) 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. ii) 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.
Medical Exclusions	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: 1. Obesity related cardiomyopathy 2. coronary heart disease 3. severe sleep apnoea 4. 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 SportsCode – 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.

C. **Specific General Exclusions**

Non Medical Exclusions	1. War or similar situations: Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. 2. Intentional self-injury or attempted suicide while sane or insane.
Medical Exclusions	1. Any Insured Person's participation or involvement in naval, military or air force operation. 2. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition"). 3. Congenital external diseases, defects or anomalies, 4. Stem cell harvesting. 5. 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). 6. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).

	7. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care. 8. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. 9. Vaccination including inoculation and immunisations (Except post Animal bite treatment) 10. Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com. 11. Treatment taken on Outpatient basis 12. The provision or fitting of hearing aids, spectacles or contact lenses. 13. 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. 14. 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. 15. 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 attached and also available on www.hdfcergo.com. 16. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form. 17. Any non-allopathic treatment except to the extent of coverage provided for under 'AYUSH Benefit' cover. 18. Prosthetic and other devices which are self-detachable/ removable without surgery involving anaesthesia 19. Treatment availed outside India 20. Treatment at a healthcare facility which is NOT a Hospital.

	21. Dental treatment and surgery of any kind, unless requiring Hospitalisation. 22. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. 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. Admission for administration of Intra-articular or Intra-lesional injections, Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc.) or IV immunoglobulin infusion.

Section D. General Conditions

I. Standard General Conditions

a. **ConditionPrecedent 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.

b. **Disclosure of Information**

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.

c. **Geography**

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

d. **Insured Person**

Only those persons named as Insured Persons in the Schedule/Certificate of Insurance shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once Wehave issued an endorsement confirming the addition of such person as an Insured Person.

Any Insured Person in the Policy has the option to migrate to similar indemnity health insurance Policy available with Us at the time of renewal subject to underwriting with all the accrued continuity benefits such as waiver of waiting period etc. provided the Policy has been maintained without a break as per portability/migration guidelines.

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

e. **Notification of Claim**

Treatment, Consultation or Procedure:	We or Our TPA must be informed:
If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency.	Within 24 hours of the Insured Person's admission to Hospital.
For all benefits which are contingent on Our prior acceptance of a claim under Section 1) a):	Within 7 days of the Insured Person's discharge post-hospitalisation.

f. **Provision for Penal Interest)**

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

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

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

d. 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.

g. **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.

h. **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

i. **Migration**:

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

For Detailed Guidelines on Migration, kindly refer the link

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

j. **Moratorium Period:**

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

k. **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.

l. **Multiple Policies**

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

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

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

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

m. **Free Look Period**

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

n. **Renewal of Policy**

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

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

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

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

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

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

o. **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.

p. **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.

q. **Nomination**

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the

event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/ Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

r. **Cancellation**

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

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

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

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

s. **Grievance Redressal Procedure**

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

- Website: www.hdfcergo.com
- Toll free: 022 6234 6234 / 0120 6234 6234
- Contact Details for Senior Citizen: 022 – 6242 – 6226 | seniorcitizen@hdfcergo.com
- E-mail: grievance@hdfcergo.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at cgo@hdfcergo.com

For updated details of grievance officer, kindly refer the link:

https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call: 022 6242 6242 / 0120 6242 6242	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call: 0022 6242 6242 / 0120 6242 6242	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call: 022 6242 6242 / 0120 6242 6242
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call: 022 6242 6226 Email id: seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call: 022 6242 6226 Email id: seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call: 022 6242 6226 Email id: seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
Visit us	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai - 400 078.	Chief Grievance Officer, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai - 400 078.

i. If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

II. Specific General Terms & Conditions

a) Cashless Service:

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

b) **Supporting Documentation & Examination**

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include to the following: Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/ reports which are not listed below:

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

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

iii) All reports and records, including but not limited to all medical reports, case histories/indoor case papers on case to case basis if required, investigation reports, treatment papers, discharge summaries.

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

v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).

vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor's invoice.

vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made

viii) All investigation, treatment and follow up records pertaining to the past ailment(s) related to the claim since their first diagnoses or detection on a case to case basis.

ix) Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident

x) Copy of settlement letter from other insurance company or TPA

xi) Stickers and invoice of implants used during surgery

xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident

xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

xiv) Legal heir certificate

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

d) **Claims Payment**

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

ii) We will only make payment to Insured Person under this Policy. Receipt of payment by Insured Person shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Insured Person's death, We will make payment to the Nominee (as named in the Schedule/Certificate of Insurance), payments

under this Policy shall only be made in Indian Rupees within India.

iii) The assignment of benefits payable under this Policy shall be subject to applicable law.

iv) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an emergency.

e) **Endorsements**

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

f) **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 Schedule ; and

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

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

a) Permanently exclude the disease/condition and continue with the Policy

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

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

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

g) **Notices**

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

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

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

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

h) **Dispute Resolution Clause**

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

Section E. Other Terms & Conditions

1. Claim Related Information

	Within India	Outside India
Claim Intimation:	Customer Service No. 022-62346234 / 0120- 62346234 Email: healthclaims@hdfcergo.com	Toll Free No: 800 08250825 Global Toll Free No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email: healthclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301,Uttar Pradesh

Ombudsman Details

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
LUCKNOW - Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.

PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Annexure I – List of Non-Medical Expenses

S. No.	Item	S. No	Item
1	BABY FOOD	26	BIRTH CERTIFICATE
2	BABY UTILITIES CHARGES	27	CERTIFICATE CHARGES
3	BEAUTY SERVICES	28	COURIER CHARGES
4	BELTS/ BRACES	29	CONVEYANCE CHARGES
5	BUDS	30	MEDICAL CERTIFICATE
6	COLD PACK/HOT PACK	31	MEDICAL RECORDS
7	CARRY BAGS	32	PHOTOCOPIES CHARGES
8	EMAIL / INTERNET CHARGES	33	MORTUARY CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	34	WALKING AIDS CHARGES
10	LEGGINGS	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
11	LAUNDRY CHARGES	36	SPACER
12	MINERAL WATER	37	SPIROMETRE
13	SANITARY PAD	38	NEBULIZER KIT
14	TELEPHONE CHARGES	39	STEAM INHALER
15	GUEST SERVICES	40	ARMSLING
16	CREPE BANDAGE	41	THERMOMETER
17	DIAPER OF ANY TYPE	42	CERVICAL COLLAR
18	EYELET COLLAR	43	SPLINT
19	SLINGS	44	DIABETIC FOOT WEAR
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
22	TELEVISION CHARGES	47	LUMBO SACRAL BELT
23	SURCHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
24	ATTENDANT CHARGES	49	AMBULANCE COLLAR
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	50	AMBULANCE EQUIPMENT

51	ABDOMINAL BINDER	60	MASK
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	61	OUNCE GLASS
53	SUGAR FREE TABLETS	62	OXYGEN MASK
54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)	63	PELVIC TRACTION BELT
55	ECG ELECTRODES	64	PAN CAN
56	GLOVES	65	TROLLY COVER
57	NEBULISATION KIT	66	UROMETER, URINE JUG
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	67	AMBULANCE
59	KIDNEY TRAY	68	VASOFIX SAFETY

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

Group Assurance Health Plan - Optional Benefit

On payment of additional premium the following benefits shall be added to the Policy coverage

Optional Benefit No. 1 – Room Rent Limit

Room and boarding expenses are subject to a limit as specified in the table below.

Options available

Options	Details
I	No room rent limit (Default option)
II	1% of Sum Insured Per day limit option and 2% of Sum Insured Per day limit option for ICU
III	2% of Sum Insured Per day limit option and 4% of Sum Insured Per day limit option for ICU

Applicable to Option II & III: In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/payment of Room Rent (including Associated Medical Expenses) incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ ICU charges.

Optional Benefit No. 2 – Pre-hospitalisation Expenses

The coverage under Pre-Hospitalisation benefit is as per limit specified in the table below	
Pre-hospitalisation Expenses	**[XX] Days***

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

Pre-hospitalisation Expenses	*15 Days	60 Days	90 Days

*The premium will be suitably reduced.

Optional Benefit No. 3 – Post-hospitalisation Expenses

The coverage under Post Hospitalisation benefit is subject to the limit as specified in the table below	
Post - hospitalisation Expenses	**[XX] Days***

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

Post-hospitalisation Expenses	*30 Days	90 Days	180 Days

*The premium will be suitably reduced.

Optional Benefit No. 4 – Hospital Daily Cash

If an Insured Person suffers an Illness or an Accident during the Policy Period that requires that Insured Person's Hospitalisation as an in-patient, then

i) We will pay Daily Cash amount for each continuous and completed period of 24 hours that the Insured Person is Hospitalised subject to maximum number of days as specified in the below table, and

Benefit	Description	
Hospital Daily Cash	Per Day Amount (Rs.)*	Maximum No. of Days*
	XXXX	XX

ii) Our maximum liability shall be restricted to the amount mentioned in the table above and limit for the benefit will apply on individual basis.

iii) We will pay twice the Daily Cash amount for each continuous and completed period of 24 hours that the Insured Person is admitted in an Intensive Care Unit, subject to maximum of 15 days per Policy Year. Whenever Intensive Care Unit benefit is admissible under the Policy, We will not pay for Daily Cash benefit in i) above for the period when the Insured Person is in Intensive Care Unit.

iv) Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to Cumulative Bonus or Health Check-up benefit, if applicable.

Note pertaining specifically to AYUSH Treatments only:

Hospital Daily Cash cover also includes coverage for In-patient care AYUSH treatments taken in an AYUSH Hospital

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned in the above Table.

Pre-hospitalisation Expenses	50 per day	100 per day	150 per day	200 per day	250 per day	300 per day
	400 per day	500 per day	750 per day	1000 per day	1500 per day	2000 per day
	2500 per day	3000 per day	3500 per day	4000 per day	4500 per day	5000 per day

Maximum No. Of Days	15	30	60	90	180

Optional Benefit No. 5 – Preventive Health Checkup (For every claim free Year)

We will reimburse the reasonable costs incurred by an Insured Person of obtaining a health check-up as per details below

i. If no claim has been made in respect of Section 1 under this Policy, then at each claim free renewal We will pay the amount mentioned below towards the cost of a preventive medical check-up

ii. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

iii. In case of family floater, if any of the members have made a claim under this Policy, the health check-up benefit will not be offered to the whole family

iv. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus, if applicable.

Option 1

Plan	1 L – 15.00 L
Individual Plan	Upto 1% of Sum Insured per Insured Person, at the end of every Policy Year subject to max of Rs 7500
Family Floater Plan	Upto 1% of Sum Insured per Policy, at the end of every Policy Year subject to max of Rs 7500

Option 2

Rs 500 to Rs 7500 (in multiples of 500) on per member basis for individual policy and policy basis for floater policies.

IMPORTANT: This benefit is not available for expenses incurred on a preventive health check-up in the first policy year. This benefit will NOT be carried forward if it is not claimed and would not be provided if the Group Assurance Health Plan Insurance Policy is not renewed further

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.

Optional Benefit No. 6 – Preventive Health Check-up Benefit

Group Assurance Health Plan - Optional Benefit

(At every renewal irrespective of claim status)

We will reimburse the reasonable costs incurred by an Insured Person of obtaining a health check-up as per details below

i. At the end of each year We will pay upto the amount mentioned below towards the cost of a preventive medical check-up.

ii.This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

iii. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus, if applicable.

Option 1

Plan	**1 L – 15.00 L**
Individual Plan	Upto 1% of Sum Insured per Insured Person, at the end of every Policy Year subject to max of Rs 7500
Family Floater Plan	Upto 1% of Sum Insured per Policy, at the end of every Policy Year subject to max of Rs 7500

Option 2

Rs 500 to Rs 7500 (in multiples of 500) on per member basis for individual policy and policy basis for floater policies.

IMPORTANT: This benefit is not available for expenses incurred on a preventive health check-up in the first policy year. This benefit will NOT be carried forward if it is not claimed and would not be provided if the Group Assurance Health Plan Insurance Policy is not renewed further

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

Optional Benefit No. 7 – Co-payment

If opted, a Co-payment of [X%] shall apply to all claims admitted under Section 1) a) of Policy. The Insured Person shall bear percentage as specified , of the eligible claim amount under the Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned.

Copayment	10%	15%	20%	30%

Optional Benefit No. 8 – Reduction / waiver of Pre-existing Disease waiting Period

The waiting period for Pre-existing Conditions have been reduced to [XX] months instead of 48 months as provided under Section 2 A)iii) of Policy wording.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Waiting Period	Waived	12 months	24 months	36 months

Optional Benefit No. 9 –Reduction / waiver of 24 months waiting period for listed conditions

The waiting period for listed disease/conditions under Section 2 A)ii) of Policy wordings have been reduced to [XX] months instead of 24 months

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Waiting Period	Waived	12 months

Optional Benefit No. 10 – 30 days waiting period waiver

Waiting period of 30 days under Section 2 A)i) of Policy wording has been waived .

Optional Benefit No. 11 – AYUSH Benefit

The coverage under this Policy is extended to reimburse the Medical Expenses incurred in Ayush Hospital for In-patient treatment care taken under Ayurveda, Unani, Sidha, Homeopathy, Yoga & Naturopathy and exclusion under section section C.C. 17. of Policy Wordings stands deleted for all Insured Persons to this extent, provided that:

i. Our maximum liability will be limited to the amounts specified in the table below

Benefit	**Description**
AYUSH Benefit	[100]% of In-patient Sum Insured*

ii. This limit will apply on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy

iii. We will not cover treatment, costs or expenses where hospitalisation is for evaluation and or for investigation purpose only, any treatment availed outside India.

Any claim made in respect of this benefit will be subject to In-patient Sum Insured and will affect entitlement to a Cumulative Bonus and Health Check-up benefit, if applicable.

Note : AYUSH Benefit 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 Base indemnity plan.

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

Optional Benefit No. 12 – E-opinion in respect of Critical Illness

We shall arrange and pay for a second opinion from Our panel of Medical Practitioners, if:

- The Insured Person suffers a Critical Illness during the Policy Period; and
- He requests an E-opinion; and

The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner.

"Critical Illness" includes Cancer of specified severity, Open Chest CABG, Myocardial Infarction (First Heart Attack of specific severity), Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with persisting symptoms, Permanent Paralysis of Limbs and Stroke resulting in permanent symptoms,

We will not pay for:

i) More than one claim for this benefit in a Policy Year.

ii) More than one claim for the same Critical Illness.

iii) Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus and Health Checkup benefit, if applicable.

Optional Benefit No. 13 – Restore Benefit

Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, Cumulative Bonus and Restore sum insured) will be available to all Insured Persons for all claims under In-patient

Group Assurance Health Plan - Optional Benefit

Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative Bonus (if applicable).

Conditions for Restore benefit:

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

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

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

d.This benefit would only be offered where Base Sum Insured is 1 lac and above.

e.The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1

Optional Benefit No. 14 – Double Restore Benefit

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

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

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

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

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

   d. This benefit would only be offered where Base Sum Insured is 1 lac and above.

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

Optional Benefit No. 15 – Cumulative Bonus

i. A Cumulative Bonusof 10% will be applied on the Sum Insured for next Policy Year by automatically increasing the Sum Insured under the Policy after every CLAIM FREE Policy Year, provided that the Policy is renewed with Us and without a break. The maximum Cumulative Bonusshall not exceed [XX%]* of the Sum Insured in any Policy Year.

ii. In relation to a Family Floater Policy, the Cumulative Bonusso applied will only be available in respect of claims made by those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

iii. If a Cumulative Bonus has been applied and a claim is made, then in the following Policy Year We will automatically decrease the Cumulative Bonusby 10% of the Sum Insured There will be no impact on the Inpatient Sum Insured, only the accrued Cumulative Bonus will be decreased.

iv. If the Insured Persons in the expiring Policy are covered on individual basis and thus have accumulated the No Claim Bonus for each member in the expiring Policy, and such expiring Policy is renewed with Us on a Family Floater basis, then the No Claim Bonus to be carried forward for credit in the Policy would be the least No Claim Bonus amongst all the Insured Persons.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Maximum Cumulative Bonus	50%	100%

Optional Benefit No. 16 – Daily Cash for choosing shared Accommodation

Daily cash amount will be payable per day as per table below, if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.

Sum Insured	Limit (Rs)
[XXXX]	Rs. [XX] per day maximum of Rs. [XXXX]

We will not pay for:

i) Daily Cash Benefit for time spent by the Insured Person in an intensive care unit

ii) Claims which have NOT been admitted under Section 1 a).

iii) Any other exclusion applied in Section C of Policy Wordings

Shared Accommodation means hospitalization in a Hospital room with two or more In-patient beds

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Sum Insured (Rs) per day	500 per day	800 per day	1000 per day	1500 per day	2000 per day

Maximum Number of Days	6	10	15

Optional Benefit No. 17 – Critical Illness

We will pay the Critical Illness Sum Insured as a lump sum in addition to Our Payment under this Policy, provided that:

a) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and

b) The Insured Person survives atleast 30 days following such diagnosis,

c) This benefit is payable once during the Policy Period andwould terminate on the occurrence of the first Critical Illness. The Insured Person shall receive the sum insured as per applicable guidelines post which the benefit will cease and coverage under this benefit would not be renewed any further. However the other insured members (if any) will continue to be covered under this benefit if opted.

d) This benefit is offered only on Individual Sum Insured basis.

e) Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus and Health Checkup benefit, if applicable.

We will not make payment if:

a) The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the Commencement Date and the Insured Person has not previously been insured continuously and without interruption under this Policy.

S.No	Critical Illness
Waiting Period	90 days
Survival Period	30 days
Important terms You should know: Survival period means the period after an insured event that the insured person has to survive before a claim is payable	

Please refer to Section A (Definition 9) of Policy wordings for the definitions of the Critical Illnesses and also exclusions specifically applicable to the critical illness covered.

Group Assurance Health Plan - Optional Benefit

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Sum insured basis	Upto 100% of base SI, subject to min of 50000 and max of 15 Lacs	
Number of CI	4	12
Waiting Period	90 days	
Survival Period	30 days	

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

Optional Benefit No. 18 – Critical Illness (Indemnity based)

An additional limit of Rs [XX] shall be available for coverage of expenses incurred on Inpatient and Day Care treatment of the below listed number of critical illnesses.

• [XX]* • [XX]*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Critical Illness (Rs)	100000	200000	300000	400000	500000	750000	1000000	1500000

The following listed critical Illnesses would be mentioned above as opted by the customer

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

Optional Benefit No. 19 – Double Sum Insured for Critical Illness (Indemnity based)

We will increase the Sum Insured for an insured person by 100% if he is diagnosed as suffering from a critical Illness under this Policy, provided that:

i) The insured person is first diagnosed as suffering from a critical illness during the Policy period, and

ii) The benefit is utilised only by the insured person diagnosed with the critical illness, and

iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

For this benefit Critical Illness means :

• [XX]* • [XX]*

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

The following listed critical Illnesses would be mentioned above as opted by the customer

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

Optional Benefit No. 20 – Double Sum Insured for Cancer of specified severity (Indemnity based)

Group Assurance Health Plan - Optional Benefit

We will increase the Sum Insured for an insured person by 100% if he is diagnosed as suffering from cancer of specified severity under this Policy, provided that:

i) The Insured Person is first diagnosed as suffering from a cancer during the Policy period, and

ii) The benefit is utilised only by the Insured Person diagnosed with the illness, and

iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

Cancer of specified severity means:

- A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- The following are excluded:
  a) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
  b) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
  c) Malignant melanoma that has not caused invasion beyond the epidermis;
  d) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
  e) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
  f) Chronic lymphocytic leukaemia less than RAI stage 3
  g) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
  h) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

Optional Benefit No. 21 – Outpatient Benefit

The coverage under this Policy is extended to reimburse expenses incurred on Outpatient Treatment for the Insured Persons mentioned in the Policy Schedule, provided that

i. You have renewed the Policy consecutively without a break for the period as stated in the table below

Benefit	Maximum Sum Insured (Rs.)
Out-patient Benefit with waiting period of [X]years	XXXXXXX

ii. Our maximum liability shall be limited to the amount specified in the table above. This limit will apply on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy and

iii. The condition of minimum Hospitalisation of 24 hours as an in-patient under Benefit 1 a) stands deleted.

iv. For the purpose of this endorsement Out-patient Treatment means medical treatment taken by an Insured Person without him being Hospitalised for 24 hours.

v. The reimbursement of claims under this extension shall be done only once during each Policy Year of the Policy Period. No claim will be admissible which is made 30 days after the expiry of Policy.

vi. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus and Health Check-up, if applicable.

***For regulatory reference**

Following options will be offered to customer for him/her to choose any one. Only the option chosen by the customer shall be mentioned above.

Sum Insured (Rs)

1000	2000	3000	4000	5000

Waiting Period

1 year	2 years	3 years

Optional Benefit No. 22 – Health and Wellness Portal

Health and Wellness services to be offered to the Insured Person through an integrated portal providing solutions on healthy living, health and lifestyle information.

Optional Benefit No. 23 – Geographical Premium

For the purpose of policy issuance, the premium will be computed based on point of sale location

The premium that would be applicable zone wise and the cities defined in each zone are as under:

Zone 1- Delhi NCR/Mumbai MMR- Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida ,Mumbai, Navi Mumbai , Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai,Virar

- **Zone 2**- Rest of India- All other cities

All other cities The premium will be modified in case of mid-term address change involving migration from one zone to another and would be calculated on pro-rata basis. Also, We will not apply any co-payment where an Insured Person pays premium in Zone 2 and avails treatment in a Zone 1.

Optional Benefit No. 24 –Personal Accident

It is hereby agreed that in the event of any Accidental Bodily Injury we will provide the Benefits as detailed below for an event or occurrence described in any of the Benefits that occurs during the Policy Period.

Each Benefit is subject to its Sum Insured, but Our liability to make payment in respect of any and all Benefits shall be limited to the Accidental Death Sum Insured unless expressly stated to the contrary. Sum Insured limit for the benefit will apply on individual basis.

For regulatory reference

If opted by the customer, Accident Death Benefit is mandatory under this benefit. However, all other benefits i.e. Optional Benefit 24.2 to Optional Benefit 24.6 would be added if opted by the customer.

Optional Benefit No. 24.1 – Accidental Death

1) Accidental Death
If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his death within 365 days from the date of the Accident, then We will pay the Sum Insured.

2) Transportation of Mortal Remains
If We have accepted a claim under 1), then We will in addition reimburse the lower of 2% of the Sum Insured under Benefit 1 above and the actual amount incurred in transporting the mortal remains of the Insured Person from the place of the Accident or the Hospital to his residence or Hospital or to a cremation or burial ground.

3) Cremation Ceremony
If We have accepted a claim 1), then We will in addition pay the lumpsum Sum Insured towards the costs of the cremation or burial of the Insured Person.

Group Assurance Health Plan - Optional Benefit

Optional Benefit No. 24.2 – Permanent Total Disablement

- If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident which is the sole and direct cause of his permanent total disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

Loss of:	% of Sum Insured
Loss of 2 Limbs (both hands or both feet or one hand and one foot)	100%
Loss of a Limb and an eye	100%
Complete and irrecoverable loss of sight of both eyes	100%
Complete and irrecoverable loss of speech & hearing of both ears	100%
Loss of a Limb	50%
Complete and irrecoverable loss of sight of an eye	50%

- In this Benefit:

a. Limb means a hand at or above the wrist or a foot above the ankle.
b. Loss of Limb means:
i. the physical separation of a Limb above the wrist or ankle respectively, or
ii. the total loss of functional use of a Limb for at least 365 days from the date of onset of such disability provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

Optional Benefit No. 24.2 – Permanent Total Disablement

- If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident which is the sole and direct cause of his permanent partial disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

Loss of:	% of Sum Insured
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	60%
Each hand at the wrist	50%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%

- In this Benefit:
  a) Loss means:
     i. the physical separation of a body part, or
     ii. the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disability provided that We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

- If an Insured Person suffers a Loss not mentioned in the table above, then We will assess the degree of disablement with an independent medical advisors and determine the amount of payment to be made.
- If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment will be limited to the member only and not any of its parts or constituents.

Optional Benefit No. 24.4 – Emergency Ambulance

If We have accepted a claim under this Policy and following the Accident it is necessary to immediately transfer the Insured Person to the nearest Hospital by ambulance offered by a healthcare or ambulance service provider, then We will in addition reimburse the actual expenses of the transfer using the shortest route upto Rs 2000.

Optional Benefit No. 24.5 – Out-patient Accident Treatment

If any Insured Person suffers an Accident during the Policy Period that requires Outpatient Treatment, then We will in addition reimburse the Medical Expenses incurred for such Insured Person provided that the Treatment commences within the Policy Period. Our liability to meet Medical Expenses caused by such Accident will be upto Benefit Sum Insured as mentioned in Policy Schedule.

Optional Benefit No. 24.6 – Broken Bones

If an Accident causes an Insured Person to suffer a fracture (a break in the continuity of a bone) and this is certified by a Doctor and also confirmed by imaging investigations such as by X-ray, then We will pay the percentage of the Sum Insured specified in the table below.

Loss of:	% of Sum Insured
Injury to vertebral body resulting in spinal cord damage	100%
Pelvis	100%
Skull (excluding nose and teeth)	30%
Chest (all ribs and breast bone)	50%
Shoulder (collar bone and shoulder blade)	30%
Arm	25%
Leg	25%
Vertebra – vertebral arch (excluding coccyx)	30%
Wrist (collies or similar fractures)	10%
Ankle (Potts or similar fracture)	10%
Coccyx	5%
Hand	3%
Finger	3%
Foot	3%
Toe	3%
Nasal bone	3%

Special Exclusions applicable with Personal Accident Benefit: Following exclusions will be applicable only for Personal Accident Benefit.

a. Special Exclusions to Optional Benefit No 24.1 – 24.5
   i. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).
   ii. Medical or surgical treatment except as necessary solely and directly as a result of an Accident.
b. Special Exclusion to Optional Benefit No 24.6
   i. Sickness or disease.
   ii. Any fracture due to osteoporosis or a malignant disease.
   iii. Any hair line fracture.

c. General Exclusion applicable to all Benefits
   i. Any Pre-existing Condition or any complication arising from the same.
   ii. Intentional self-injury or attempted suicide while sane or insane.
   iii. War or similar situations:
   Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.
   iv. 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.
   v. 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.
   vi. Treatment forAlcoholism, drug or substance abuse or any addictive condition and consequences thereof.
   vii. 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.
   viii. External congenital diseases, defects or anomalies or in consequence thereof.
   ix. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Person's family.
   x. Any non-allopathic treatment.

Special Conditions applicable with Personal Accident Benefit: In addition to the General Conditions mentioned in the Section 3 of policy wordings, the below mentioned conditions are applicable for Personal Accident Benefitas and when applicable.

a. Notification of claim
   i. We must be informed of any event or occurrence that may give rise to a claim under this Policy within 30 days of it happening
   ii. For all benefits contingent on Our prior acceptance of a claim under Optional Benefit 24.1 – 24.3, We must be informed within 30 days of the event or occurrence that may give rise to a contingent benefit claim.
   iii. If any time period is specifically mentioned in Optional Benefit 24, then this shall supersede the time periods mentioned at i) and ii) above.

b. Claims Payment Supporting Documentation & Examination
   i. We must be provided with any documentation and information We may request to establish the circumstances of the claim, its quantum or Our liability for it including, Our claim form duly completed and all reports, including death certificate, post mortem report , disability certificate, medical reports, case histories, investigation reports, treatment papers and discharge summaries. Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/ reports.
   ii. The Insured Person additionally hereby consents to:
      a) The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.
      b) The Insured Person shall be examined by any medical practitioner We authorise for this purpose when and so often as We may reasonably require.

c. Claims Payment

i) If We accept a claim and become liable to make payment under Permanent Total Disablement Benefit, Permanent Partial Disablement Benefit and Broken Bones (the first claim) and there is a subsequent claim under other Benefit or Accidental Death Benefit in respect of the same Insured Person and the same Accident within 365 days of the date of the Accident (the second claim), then We will only be liable to pay the difference between the amount payable for the first claim and the amount payable for the second claim.

ii) Payments under this Benefit shall only be made in Indian Rupees irrespective of the location of accident which has given rise to the claim.

d. Insured Person

If an Insured Person opts for Optional Benefit No. 24, then We will cover any Insured Persons from the age of 91 days onwards and there is no cover ceasing age for this benefit.

e. Change of Occupation

You will give Us a written notice in the format prescribed by Us of any change in the business or occupation of any Insured Person within 30 days of such change and We will issue an endorsement to this effect.
If at the time a claim arises under this Policy the Insured Person has changed his occupation without Us being notified, then Our maximum liability will be limited to the amount that would have been payable for the premium paid and the new occupation.

f. Geography

This Benefitof Personal Accident applies to events or occurrences taking place anywhere in the world unless limited by Us in a particular Benefit or definition or through an endorsement.

g. Nomination

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