HDFC ERGO General Insurance Company Limited

Policy Wordings

Health Suraksha -Top Up Pro

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PREAMBLE

HDFC ERGO General Insurance Company Limited will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the terms and conditions of this Policy, Your payment of premium, and Your statements in the Proposal, which is incorporated into the Policy and is the basis of it.

SECTION A. DEFINITIONS

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

Def. 2. **Any one illness** means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken

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

a. Central or State Government AYUSH Hospital; or

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

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

i. Having at least 5 in-patient beds;

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

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

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

Def. 4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

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

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

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

Def. 5. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

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

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

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

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

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

Def. 9. **Day care Centre** means any institution established for Day Care Treatment of Illness and / or injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-

I. has qualified nursing staff under its employment;

II. has qualified medical practitioner/s in charge;

III. has fully equipped operation theatre of its own where surgical procedures are carried out;

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

Def. 10. Day Care Treatment/ Proceduresmeans those medical treatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and

ii) which would have otherwise required Hospitalization of more than 24 hours,

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

Def. 11. **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. 12. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

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

Def. 14. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury 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

Def. 15. **Emergency Care** means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health.

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

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

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

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

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

2. it needs ongoing or long-term control or relief of symp toms

3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

4. it continues indefinitely

5. 5. it recurs or is likely to recur

Def. 20. **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. 21. **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. 22. **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. 23. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 24. **Maternity Expenses** means

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

b. Expenses towards lawful medical termination of pregnancy during the policy Period.

Def. 25. **Medical Advice** means any consultation or advise from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 26. **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. 27. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

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

Def. 30. **Network Provider** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured by a cashless facility.

Def. 31. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network

Def. 32. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized mode of communication.

Def. 33. **OPD Treatment** means 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 daycare or inpatient.

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

Def. 35. **Pre- Hospitalisation Medical Expenses** means the Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person ,provided that:

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

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

Def. 36. **Post- Hospitalisation Medical Expenses** means the

Medical Expenses incurred during the pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that:

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

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

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

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

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

Def. 38. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 39. **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. 40. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the Associated medical expenses.

Def. 41. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all gaining credit for pre-existing diseases, time- bound exclusions and for all waiting periods.

Def. 42. **Surgery or Surgical Procedure** means manual and/ or operative procedure(s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner

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

Specific Definitions

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

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

Def. 3. **Alternative treatments** means forms of treatments other than treatment "Allopathic" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Def. 4. **Associated Medical Expenses** means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def. 5. **AYUSH Treatmen**t refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system

Def. 6. **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 7. **Biological attack or weapons** the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 8. **Chemical attack or weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 9. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule.

Def. 10. **Contribution** means essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion of Sum Insured.

Def. 11. **Dependents** means only the family members listed below:

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

b) Your children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households;

c) Your natural parents or parents that have legally adopted You, and Your parents in law

Def. 12. **Family Floater** means a Policy described as such in the Policy Schedule where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date.

Def. 13. **Insured Person** means the persons named in the Policy Schedule and insured under the Policy.

Def. 14. **Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 15. **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. 16. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule

Def. 17. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 18. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Year

Def. 19. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited

Def. 20. **You/Your/Policyholder** means the person named in the Policy Schedule who is insured under the Policy or has proposed and concluded this Policy with Us.

SECTION B: BENEFITS

I. Hospitalisation Cover

Claims made in respect of any of the benefits below will be subject to the Sum Insured and will affect entitlement to a Cumulative bonus.

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's Hospitalisation as an inpatient, then We will pay for the Medical Expenses for the benefits mentioned below, in excess of the Deductible stated in the Schedule.

Our maximum liability for a continuous period of Illness, including relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Schedule of Benefits. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

1. In-patient Treatment

The Medical Expenses for:
i. Room rent, boarding expenses, Nursing,
ii. Intensive care unit,
iii. Medical Practitioner(s),
iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
v. Medicines, drugs and consumables,
vi. Diagnostic procedures,
vii. The Cost of prosthetic and other
viii. Medical devices or equipment if implanted internally during a Surgical Procedure.

Note pertaining specifically to AYUSH Treatments only:
Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient Treatment' cover if undertaken in an AYUSH Hospital. However, any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.

2. Pre-Hospitalisation

The Pre-Hospitalization Medical Expenses incurred in the 60 days immediately before the Insured Person was Hospitalized, provided that:

Such Medical Expenses were in fact incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

3. Post-hospitalisation

The Post-hospitalization Medical Expenses incurred in the 90 days immediately after the Insured Person was discharged post Hospitalisation provided that:

Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalisation was required, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

4. Day Care Procedures

The Medical Expenses for a day care procedure mentioned in the list of Day Care Procedures in this Policy where the procedure or surgery is taken by the Insured Person as an inpatient for less than 24 hours in a Hospital or standalone day care centre but not the outpatient department of a Hospital or standalone day care centre.

5. Domiciliary Treatment

The Medical Expenses incurred by an Insured Person for medical treatment taken at his home which would otherwise have required Hospitalisation because, on the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or a Hospital bed was unavailable, and provided that:

The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the

reasonable charge of any necessary medical treatment for the entire period, and

6. Organ Donor

The Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

The organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended) and The organ donated is for the use of the Insured Person, and We will not pay the donor's pre and post-Medical Expenses or any other medical treatment for the donor consequent on the harvesting, and

We have accepted an inpatient Hospitalisation claim under Benefit I.1).

7. Emergency Ambulance

We will reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate Emergency facilities for the provision of health services following an Emergency, provided that:

Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and We have accepted an inpatient Hospitalisation claim under Benefit I.1).

The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, provided that transportation has been prescribed by a Medical Practitioner and is medically necessary.

II. Renewal Benefit

1. Cumulative Bonus

a) If no claim has been made under this Policy and the Policy is renewed with Us without any break, We will apply a cumulative bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 5% of the Sum Insured for this Policy Year. The maximum cumulative bonus shall not exceed 50% of the Sum Insured in any Policy Year.

b) In relation to a Family Floater, the cumulative bonus so accrued will only be available only to insured persons in the claim free year who continue to be Insured Persons in the subsequent Policy Year.

c) If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year we will automatically decrease the cumulative bonus by 5% of the Sum Insured in that following Policy Year.

SECTION C: WAITING PERIODS AND EXCLUSIONS

1. Standard Exclusions and Waiting Period

Waiting Periods

d) Claims under the Policy are covered subject to waiting Period as specified below:

Pre-existing Diseases - Code - Excl01

i. 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.

ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.

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

iv. 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.

Specified Disease/Procedure waiting period: Code - Excl02

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.

ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.

iii. 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.

iv. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i) Illnesses: arthritis if non infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/ fistula in anus, hemorrhoids, pilonidal sinus, gastric and

duodenal ulcers; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); osteoarthritis and osteoporosis; polycystic ovarian diseases; sinusitis, Rhinitis, Tonsillitis and skin tumors unless malignant.

ii) Treatments: benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy; joint replacement; myomectomy for fibroids; surgery of gallbladder and bile duct unless necessitated by malignancy; surgery of genito urinary system unless necessitated by malignancy; surgery of benign prostatic hypertrophy; surgery of hernia; surgery of hydrocele; surgery for prolapsed inter vertebral disk; surgery of varicose veins and varicose ulcers; surgery on tonsils and sinuses; surgery for nasal septum deviation.

30 day Waiting Period: Code- Excl03

i. 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.

ii. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Permanent Exclusions

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

i. Investigation & Evaluation: Code Excl04

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

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

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

a. Surgery to be conducted is upon the advice of the doctor

b. The surgery/procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and
d. Body Mass Index (BMI)

i. Greater than or equal to 40 or,

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

1. Obesity related cardiomyopathy

2. coronary heart disease

3. severe sleep apnoea

4. uncontrolled type2 diabetes

iv. **Change-of-Gender treatments** - Code – Excl07:Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. **Cosmetic or plastic surgery**: Code – Excl08:Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of **Medically Necessary Treatment** to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi. **Hazardous or Adventure Sports** Code – Excl09– Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

vii. **Breach of Law:** Code – Excl10 - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

viii. **Excluded Providers-** Code – Excl11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

ix. **Treatment** for Alcoholism, drug or substance abuse or any

addictive condition and consequences thereof.Code – Excl12

x. **Treatments** received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.Code – Excl13

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

xii. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15

xiii. 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

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

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

xv. **Maternity:** Code – Excl18

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

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

2. Specific Exclusions

i. Deductible

We are not liable for any payment unless the Medical Expenses exceed the Deductible (as opted on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy). Deductible shall be applicable per Policy Year basis.

ii. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical or Biological attack or weapons, radiation of any kind.

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

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

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

vi. Congenital external diseases, defects or anomalies,

vii. Stem cell harvesting

viii. Investigative treatments for analysis and adjustments of spinal subluxation,diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

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

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

xi. 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.

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

xiii. 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.

xiv. Treatment taken on Outpatient basis

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

xvi. 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.

xvii. 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.

xviii. 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

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

SECTION B: BENEFITS

Standard General Conditions

1. Condition Precedent to admission of Liability

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

2. Disclosure of Information

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

3. Claim Settlement (Provision for Penal Interest)

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

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

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

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

v. Our liability to make payment under this policy will only begin when the Deductible as mentioned in Schedule is exceeded. We will pay to the Insured Person, Medical Expenses over and above Deductible but not exceeding the Sum Insured for the Policy Period.

vi. 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.

vii. This Policy only covers medical treatment taken within India, and payments under this Policy shall only be made in Indian Rupees within India.

viii. In case of any other concurrent health insurance policy, the amount paid by the other insurer for emergency ambulance would be deducted from the amount claimed under Section B.I-7 Emergency Ambulance of Health Suraksha – Top up Pro Policy, subject to the actual or Rs 2000 whichever is less.

4. 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.

5. Fraud

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

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who 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.

6. 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.

7. 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.

8. 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

9. Migration

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

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

10. Renewal of Policy

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

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

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

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

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the 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.

11. Cancellation

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

1 Year Policy		2 Year Policy	
Length of time Policy in force	Refund of premium	Length of time Policy in force	Refund of premium
Upto 1 Month	75.00%	Up to 1 Month	87.50%
Upto 3 Months	50.00%	Up to 3 Months	75.00%
Upto 6 Months	25.00%	Up to 6 Months	62.50%
Exceeding 6 Months	Nil	Up to 12 Months	50.00%
		Up to 15 Months	37.50%
		Up to 18 Months	25.00%
		Exceeding 18 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.

12. 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.

13. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates.

The Insured Person shall be notified three months before the changes are effected.

14. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

15. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the 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.

16. Grievance Redressal Procedure

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

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

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at cgo@hdfcergo.com For updated details of grievance officer, kindly refer the link: https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@ hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@ hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@ hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

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

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

Specific General Conditions

1. Insured Person

Only those persons named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

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

2. Loadings

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

Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days. We will not apply any additional loading on Your policy premium at Renewal based on claim experience in Your Policy.

Please note that We will issue Policy only after getting Your consent.

3. Notification of Claim

	Treatment, Consultation or Procedure:	**We or Our TPA must be informed:**
1)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalization:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
2)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalization in an Emergency:	Within 24 hours of the Insured Person's admission to Hospital.
3)	For all benefits which are contingent on Our prior acceptance of a claim under Section B.I-1:	Within 15 days of the Insured Person's discharge post hospitalization.
4)	If any treatment, consultation or procedure for which a claim may be made is required in an Emergency:	Within 15 days of completion of such treatment, consultation or procedure.
5)	In all other cases:	Of any event or occurrence that may give rise to a claim under this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorize such treatment, consultation or procedure.

Note: In the case of a covered Hospitalization, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with a copy of intimation made to the other insurer /Reimbursement Provider immediately but not later than 15 days on knowing that the Deductible is likely to be exceeded.

4. Cashless service:

	Treatment, Consultation or Procedure:	**Treatment, Consultation or Procedure Taken at:**	**Cashless Service is Available:**	**We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:**
1)	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 Hospitalization
2)	If any treatment, consultation or procedure for which a claim may be made is 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 Hospitalization

5. 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. Such documentation will include but is not limited to the following:

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

ii. Original Bills (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. All hospitalisation expenses incurred in the Hospital must comprise within the Bill from Hospital. Any expenses incurred during Hospitalisation but not part of final bill will not be admissible.

iii. All reports, including but not limited to all medical reports, case histories, 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.

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.

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.

The Insured Person additionally hereby consents to:

i) The disclosure to Us of documentation, medical records and information that may be held by medical professionals and other insurers.

ii) Being examined by any Medical Practitioner We authorise for this purpose when and so often as We may reasonably require at Our cost.

6. Alterations to the Policy

This Policy constitutes the complete contract of insur- ance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except Us, and any change We make will be evidenced by a written endorse- ment signed and stamped by Us.

7. 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 Com- pany to invoke cancellation under clause (i) above.

8. Grace Period

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

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

9. Change of Policyholder

The change of Policyholder (except clause XXII) is per- mitted only at the time of renewal. If You do not renew the Policy, the other Insured Persons may apply to renew the Policy. However, in case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court subject to condition q) above.

10. Notices

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

i) Any Insured Person, then it shall be sent to You at Your address specified in the Schedule and You shall act for all Insured Persons for these purposes.

ii) Us, it shall be delivered to Our address specified in the Schedule. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

11. 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

Contact Us

	Within India	Outside India
Claim Intimation:	Toll Free: 022 6234 6234 / 0120 6234 6234 Email:healthclaims@hdfcergo.com	Toll Free No: 800 08250825 Global Toll Free No: +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email: travelclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, Andheri Kurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

List of Ombudsman

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - 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.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	Jurisdiction of Office Union Territory, District
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, 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

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	Jurisdiction of Office Union Territory, District
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
LUCKNOW - Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I - List of Non-Medical Expenses

S. No.	Item
1	Baby food
2	Baby utilities charges
3	Beauty services
4	Belts/ braces
5	Buds
6	Cold pack/hot pack
7	Carry bags
8	Email / internet charges
9	Food charges (other than patient's diet provided by hospital)
10	Leggings
11	Laundry charges
12	Mineral water
13	Sanitary pad
14	Telephone charges
15	Guest services
16	Crepe bandage
17	Diaper of any type
18	Eyelet collar
19	Slings
20	Blood grouping and cross matching of donors samples
21	Service charges where nursing charge also charged
22	Television charges
23	Surcharges
24	Attendant charges
25	Extra diet of patient (other than that which forms part of bed charge)
26	Birth certificate
27	Certificate charges
28	Courier charges
29	Conveyance charges
30	Medical certificate
31	Medical records
32	Photocopies charges
33	Mortuary charges
34	Walking aids charges
35	Oxygen cylinder (for usage outside the hospital)
36	Spacer
37	Spirometre
38	Nebulizer kit
39	Steam inhaler
40	Armsling
41	Thermometer
42	Cervical collar
43	Splint
44	Diabetic foot wear
45	Knee braces (long/ short/ hinged)
46	Knee immobilizer/shoulder immobilizer
47	Lumbo sacral belt
48	Nimbus bed or water or air bed charges
49	Ambulance collar
50	Ambulance equipment
51	Abdominal binder
52	Private nurses charges- special nursing charges
53	sugar free tablets
54	Creams powders lotions (toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	Ecg electrodes
56	Gloves
57	Nebulisation kit
58	Any kit with no details mentioned [delivery kit, orthokit, recovery kit, etc]
59	Kidney tray
60	Mask
61	Ounce glass
62	Oxygen mask
63	Pelvic traction belt
64	Pan can
65	Trolly cover
66	Urometer, urine jug
67	Ambulance
68	Vasofix safety

SCHEDULE OF BENEFITS

Health Suraksha - Top up **Pro- Individual**

Benefits	**Sum Insured**
Sum Insured (Rs. in Lac) per Policy per Policy Year	2.00; 3.00; 4.00; 5.00; 7.50; 10.00
Deductible (Rs. In Lacs) (As mentioned in Policy Schedule)	1.00; 2.00; 3.00; 4.00; 5.00
1 a) In-patient Treatment	Covered; Hospitalization for minimum 24 hours required.
1 b) Pre-hospitalization	Covered, maximum up to 60 days
1 c) Post-hospitalization	Covered, maximum up to 90 days
1 d) Day Care Procedures	Covered
1 e) Domiciliary Treatment	Covered
1 f) Organ Donor	Covered
1 g) Emergency Ambulance	Up to Rs. 2000 per Hospitalization.

Health Suraksha - Top up Pro- Family Floater

Benefits	**Sum Insured**
Sum Insured (Rs. in Lac) per Policy per Policy Year	2.00; 3.00; 4.00; 5.00; 7.50; 10.00
Deductible (Rs. In Lacs) (As mentioned in Policy Schedule)	1.00; 2.00; 3.00; 4.00; 5.00
1 a) In-patient Treatment	Covered; Hospitalization for minimum 24 hours required.
1 b) Pre-hospitalization	Covered, maximum up to 60 days
1 c) Post-hospitalization	Covered, maximum up to 90 days
1 d) Day Care Procedures	Covered
1 e) Domiciliary Treatment	Covered
1 f) Organ Donor	Covered
1 g) Emergency Ambulance	Up to Rs. 2000 per Hospitalization.