Day2DayCare- Policy Wordings

Contents

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:

1. Standard Definition

Def 1. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Def 2. **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 approved.

Def 3. **Condition Precedent** Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def 4. **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 claim amount. A co-payment does not reduce the Sum Insured.

Def 5. **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def 6. **Disclosure to information norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

Def 7. **Grace Period** the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def 8. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has at least 10 in-patient beds, in those 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 9. **Illness** 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.

i. 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.

ii. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests-it needs ongoing or long-term control or relief of symptoms-it requires your rehabilitation or for you to be specially trained to cope with it continues indefinitely-it comes back or is likely to come back.

Def 10. **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 11. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def 12. **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 13. **Pre- Hospitalisation Medical** Expenses means the Medical expenses incurred immediately before the Insured Person is Hospitalised, 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 14. **Post- Hospitalisation Medical Expenses** means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:

iii. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
iv. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

Def 15. **Medical Practitioner** 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 licence.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 MedicalPractitioner under the scope of this Policy.

Def 16. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def 17. **Network Provider or Network centre** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

Def 18. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network.

Def 19. **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timeliness as well as the address / telephone number to which it should be notified.

Def 20. **Outpatient Treatment** is 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 21. **Portability** means, a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

Def 22. **Reasonable and Customary Necessary** means the charges for services or supplies, which are the standardcharges 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 23. **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

2. Specific Definitions

Def 1. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def 2. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def 3. **Dependent Child or Children** means Your children Aged between 91 days and 25 years at the commencement of the Policy Period if they are unmarried, still financially dependent on You and have not established their own independent households.

Def 4. **Dependents**means only the family members listed below:

i) Your legally married
ii) Your children Aged between 91 days and 25 years if they are unmarried, still financially dependant on You and have not established their own independent households;
iii) Your natural parents or parents that have legally adopted You, provided that:
   a) The parent was below 65 years at his initial participation in the Day2DayCarePolicy, and
iv) Your Parent-in-law as long as Your spouse continues to be married to you and werebelow 65 years at their initial participation in the plan.

All Dependent parents must be financially dependent on You.

Def 5. **Family Floater**means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our

maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def 6. **Clinical establishment** means a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities requiring diagnosis, treatment or care for illness,injury,deformity,abnormality or pregnancy in any recognised system of medicine established and administered or maintained by any person or body of persons, whether incorporated or not; or A place established as an independent entity or part of an establishment referred to above in connection with the diagnosis or treatment of diseases where pathological,bacteriological,genetic,radiological,chemical,biological investigations or other diagnostic or investigative services with the aid of a laboratory or other medical equipment , are usually carried on, established and administered or maintained by any person or body of persons, whether incorporated or not and shall include a clinical establishment owned, controlled or managed by the Government or a department of the Government, a trust, whether public or private; a corporation (including a society) registered under a Central, Provincial or State Act, whether or owned by the Government; a local authority and a single doctor but does not include the clinical establishment owned , controlled or managed by the Armed forces.

Def 7. **Age** or **Aged** means completed years as at the Commencement Date.

Def 8. **Bank rate** shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

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

Def 11. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence;

Def 12. **Mental Health** Establishment means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

Def 13. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def 14. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def 15. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def 16. **Pathology means** laboratory testing of blood and other bodily fluids, tissues, and microscopic evaluation of individual cells

Def 17. **Radiology** means the branch of medicine that deals with diagnostic images of anatomic structures through the use of electromagnetic radiation or sound waves and that treats disease through the use of radioactive compounds. Radiologic imaging techniques include x-rays, CAT scans, PET scans, MRIs, and ultrasonograms

Def 18. **We/Our/Us** means the HDFC ERGO Health Insurance Limited

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

Section B. Salient Features & Benefits

The Policymay be obtained by the Insured Person for his own use or for any other insured person for one of the specified treatments, consultations or other specified benefits at a clinical establishment under the sections mentioned in a) to c)below:

a) Outpatient Consultations

This benefit covers unlimited Outpatient consultations by a general Medical Practitioner(s) or a specialist Medical Practitioner(s). A maximum of upto 5 consultations can be availed in a policy year for general or specialized consultation after applying a co-pay of 20% in non network centers. The coverage under this benefit will cover consultation services availed under Allopathy, Ayurveda, Unani, Siddha and Homeopathy.

b) Diagnostics, Vaccination, Physiotherapy & Pharmacy

This benefit covers outpatient diagnostic tests including pathology and radiology, cost and administration of vaccination by a medical practitioner, physiotherapy andpharmacy expenses for treatment under Allopathy, Ayurveda, Unani, Siddha and Homeopathy.A co-pay of 20% would be applicable on the benefit limit mentioned in the schedule of benefits in non-network centres and non network pharmacies.

c) Annual Health Check-Up (Applicable to Gold Plan only)

This benefit covers a health check-up as specified in the Schedule of Benefits for the Insured Person within Network in an individualpolicy. 2 health check-ups would be offered in a family floater policy.
In non-network centers the insured can avail the Health Check-up benefit upto a maximum of Rs 2000 per memberin an Individual policy & upto Rs 4000 per policyin a Family Floater policy.
For two year policy'sthe insured can avail one health checkup per year per member in case of Individual policy & two health check-up per year per policy for a family floater policy.

Section C. Exclusions & Waiting Period

1. Waiting Period

There is no waiting period in the plan.

2. Standard General 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:

Non Medical Exclusions	1. 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.
Medical Exclusions	1. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code-Excl12** 2. Treatments received in heath 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**

3. Specific General Exclusions

Non Medical Exclusions	4. Intentional self-injury or attempted suicide while sane or insane
Medical Exclusions	5. Inpatient treatment & day care procedures;

Section D. General Conditions

1. Standard General Conditions

a. Condition precedent to Admission of Liability

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

b. **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.

c. 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.

d. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The

moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

e. Fraud :

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

f. Multiple Policies

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

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

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

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

g. 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.

h. 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.

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

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

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

e) Renewal premium due can be paid prior to the due date as per norms set out by the Company.

j. 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.

k. 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.

l. Cancellation

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

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

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

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

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

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 thirty 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. 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 30 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.

o. Grievance Redressal Procedure

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

- Website: www.hdfcergo.com
- Contact us at: 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/	https://www.hdfcergo.com/ customer-care/grievances/	https://www.hdfcergo.com/ customer-care/grievances/

	customer-care/ grievances Call - : 022 6234 6234 / 0120 6234 6234	escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	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/

2. Specific General Conditons

a. Geography

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

b. Insured Person

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. Any eligible person may be added at renewal after his application has been accepted by Us and premium has been received. Member addition is allowed only at renewal and not during the policy period.

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 cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines.

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

c. Discounts:

We will provide a Multi-Product discount of 10% on the Day2DayCare premium if it is purchased along with Easy Health, Optima Restore or Total Health Plan of sum insured Rs.3 Lacs and above and 5% discount if purchased along with Optima Super with Deductibles of Rs.1Lac to 3 Lacs at the time of renewal or fresh policy. To avail this discount the insured persons covered under Day2DayCare policy , must be covered in the other policy as well.

The Multi product discount will not be cumulated in case an Insured person is buying multiple policies and the highest discount as per multi product discount guidelines would apply.

An additional discount of 7.5% will be provided if insured person is paying two year premium in advance as a single premium. These discounts shall be applicable at inception and renewal of the policy.

A discount of 5% on published premium will be offered, if customer buys Day2DayCare Policy through our direct channels.

d. Supporting Documentation & Examination

In case of reimbursement claims, the Insured Person shall provide Us with any documentation and information We may request to establish the circumstances of the claim under Plan its quantum or Our liability for the claim within 15 days of Our request. 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. 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 (consultation bill, pharmacy purchase bill, physiotherapy bill, diagnostic bill, vaccination bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

The Insured Person additionally hereby consents to:

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

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

e. Claims Payment

i). We will be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We 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 You under this Policy. In the event of Your death, Wewill make payment to the Nominee (as named in the Schedule).The assignment of benefits of the policy shall be subject to applicable law.

iii). The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.

iv). 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 ofintimation to the date of payment of claim at a rate 2% above the bank rate.

v). In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.

f. Non-Disclosure or Misrepresentation:

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 3 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

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

g. 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.

h. Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

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

i. Notices

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

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

j. Dispute Resolution Clause

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

Section E. Others

1. Others Conditions:

Claims made in respect of any of the benefits in this policywill be subject to the plan selected. However, Our maximum liability for each benefit under the selected plan shall be limited to the amount specified in the Schedule of Benefits against such benefit.An Insured Person shall only be eligible to take the treatment, consultation or avail the other covered benefits under the opted planif all of the following requirements are satisfied:

a) The treatment, consultation or other benefits as specified in the policyis taken or undergone by the Insured Person during the Policy Period.
b) The payment of premium in full and in time.

2. Claim Related Information

	Within India	**Outside India**
Claim Intimation:	**Contact No** :022 6234 6234 / 0120 6234 6234 **Phone (UAN)** :1860 2000 700 (Local charges applicable) **Fax (UAN)** : 1860 2000 600 (Local charges applicable) **Email**:healthclaims@hdfcergo.com	**Global Contact 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, AndheriKurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

List of Ombudsman

S.No	**Office Details**	**Jurisdiction of Office (Union Territory,District)**
1	**AHMEDABAD** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

2	**BENGALURU** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
3	**BHOPAL** Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202: Email : bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
4	**BHUBANESWAR** Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
5	**CHANDIGARH** Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
6	**CHENNAI** S Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
7	**DELHI** Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

	Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	
8	**GUWAHATI** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
10	**JAIPUR** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
11	**KOCHI** Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
12	**KOLKATA** Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341	West Bengal, Sikkim, Andaman & Nicobar Islands.

	Email: bimalokpal.kolkata@cioins.co.in	
13	**LUCKNOW** Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	**MUMBAI** Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
15	**NOIDA** Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
16	**PATNA** Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
17	**PUNE** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

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

Schedule of Benefits

SILVER PLAN				
	Individual	**Family Floater**		
	1 member	**2 members**	**3 members**	**4 members**
Outpatient Consultation (general & specialized)	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**
Pharmacy & Diagnostics (including Pathology; radiology; vaccination; physiotherapy)	Network - Upto Rs 5000/Year Non Network- Upto Rs. 5000/year after applying 20% co-pay	Network - Upto Rs 6000/Year Non Network- Upto Rs. 6000/year after applying 20% co-pay	Network - Upto Rs 7000/Year Non Network- Upto Rs. 7000/year after applying 20% co-pay	Network- Upto Rs 8000/Year Non Network- Upto Rs. 8000/year after applying 20% co-pay
Health check	NA	NA	NA	NA

GOLD PLAN				
	Individual	**Family Floater**		
	1 member	Upto 2 members	Upto 3 members	Upto 4 members
Doctor Consultation (general & specialized)	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**	**Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network**
Pharmacy & Diagnostics (including Pathology; radiology; vaccination;physiotherapy)	Network - Upto Rs 5000/Year Non Network- Upto Rs. 5000/year after applying 20% co-pay	Network - Upto Rs 6000/Year Non Network- Upto Rs. 6000/year after applying 20% co-pay	Network - Upto Rs 7000/Year Non Network- Upto Rs. 7000/year after applying 20% co-pay	Network- Upto Rs 8000/Year Non Network- Upto Rs. 8000/year after applying 20% co-pay
Health check	Annual Health Check Up at network centre	2 Annual Health Check-Ups at networkcentre	2 Annual Health Check-Ups at network centre	2 Annual Health Check-Ups at network centre Non-Network: Upto a

	Non-Network: Upto a maximum of Rs 2000 per member	Non-Network: Upto a maximum of Rs 4000 per policy.	Non-Network: Upto a maximum of Rs 4000 per policy .	maximum of Rs 4000 per policy.