

Product Name – Total Health Plan

• Sum Insured - 5 Lakhs

• Tenure – 1 Year

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of 10%	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
7	4,687	5	4,687	469	4,218	5	12,769	NA	12,769	5
10	4,687	5	4,687	469	4,218	5		NA		
35	5,599	5	5,599	560	5,039	5		NA		
40	6,336	5	6,336	634	5,702	5		NA		
	21,309				19,178				12,769	
	Total premium for all members of the family is Rs. 21,309 when each member is covered separately.		Total premium for all members of the family is Rs.19,178 when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs.12,769			
	Sum Insured available for each individual is Rs. 5 Lakhs		Sum Insured available for each individual is Rs. 5 Lakhs.				Sum Insured of Rs. 5 Lakhs is available for the entire family.			

Premium as mentioned above are exclusive of taxes.

Above premium examples are for Illustration purpose only, terms and conditions apply.



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Policy Wording

TOTAL HEALTH PLAN

Preamble

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

Section A. DEFINITIONS

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

1. Standard Definitions

Def. 1. Accident or Accidental means a sudden, unforeseen and involuntary event caused by external and visible means

Def. 2. Any One Illness means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/nursing home where treatment may have been taken.

Def. 3. 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. 4. Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 5. 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. 6. Emergency Care means management for a severe 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. 7. Congenital Anomaly An external congenital anomaly refers to a condition(s) which is present since birth, in the visible and accessible parts of the body, and which is abnormal in reference to form, structure or position.

a) Internal Congenital Anomaly: Which is not in the visible

and accessible parts of the body is called Internal Congenital Anomaly

b) External Congenital Anomaly: Which is in the visible and accessible parts of the body is called External Congenital Anomaly.

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

Def. 9. Critical Illness means Cancer of specified severity, Open Chest CABG, First Heart Attack of specified severity, Kidney Failure requiring regular dialysis, Major Organ/ Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs, Stroke resulting in Permanent Symptoms as defined below only:

i) Cancer of specified severity:

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

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

viii. All Gastro-Intestinal Stromal Tumors histologically

classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ii) Open Chest CABG:

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

II. The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

ii) First Heart Attack of Specified Severity:

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

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

iv) Major Organ/ Bone Marrow Transplant:

I. The actual undergoing of a transplant of:

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

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

v) The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

vi) Multiple Sclerosis with Persisting Symptoms:

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

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

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded..

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

viii) Stroke resulting in Permanent Symptoms:

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

Def. 10. Cumulative Bonus means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 11. 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. 12. Day Care treatments means those medical treatment, and/or surgical procedure listed in Appendix 1 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 a Hospitalisation of more than 24 hours,

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

Def. 13. Dental Treatment means treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery / implants

Def. 14. 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. 15. 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. 16. Hospitalisation or Hospitalised means admission in a Hospital for a minimum of 24 In patient care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 17. 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.

a) Acute Condition means the medical condition that can be

cured by treatment

b) Chronic Condition means 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—it continues indefinitely—it comes back or is likely to come back.

Def. 17. 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. 19. 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. 20. 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. 21. Maternity Expense / Treatment means the expense / treatment that include the following Medical treatment Expenses:

- Medical Expenses for a delivery (including complicated deliveries and cesarian sections) incurred during hospitalisation
- The lawful medical termination of pregnancy during the policy period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person
- Pre-natal and Post-natal Medical Expenses for delivery or termination.

Def. 22. Medical Advise means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription

Def. 23. 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.

i) 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 Hospitalisation is admissible by the Insurance Company

ii) Post-hospitalisation Medical Expenses means the Medical Expenses incurred immediately after 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 Hospitalisation is admissible by the Insurance Company

Def. 24. Medically Necessary means any treatment, tests, 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. 25. Medical Practitioner means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his 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. 26. 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. 27. 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 on payment by a cashless facility.

Def. 28. New Born Baby means those babies born to you and your spouse during the Policy Period aged between 1 day and 90 days.

Def. 29. Non Network means any Hospital, day care centre or other provider that is not part of the Network.

Def. 30. 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. 31. Out-patient Treatment means the treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 32. Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Def. 33. Pre-existing Condition means any condition, ailment, injury or disease:

iii) 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

iv) 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. 34. 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. 35. Reasonable 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. 36. Room Rent means the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses.

Def. 37. 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 waiting periods.

Def. 38. Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 39. Domiciliary Treatment 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:

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

Def. 40. Unproven / Experimental treatment is treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

2. 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. Such sport / activity.

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

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

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

Def. 5. 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. 6. Dependents means only the family members listed below:

- i) Your legally married spouse as long as she continues to be married to You;
- ii) Your children Aged between 1 day and 25 years if they are unmarried and financially dependent with no independent source of income. Children Aged between 1 to 90 Days can be covered if Newborn Baby Benefit is added by payment of additional premium subject to policy terms and conditions.
- iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Total Health Plan Policy, and
- iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Total Health Plan Policy
- v) All Dependent parents and Dependent in Laws must be financially dependent on You.

Def. 7. Commencement Date means the commencement date of this Policy as specified in the Schedule.

Def. 8. Dependent Child means a child (natural or legally adopted), who is unmarried, age between 91 days to 21 years, financially dependent on the primary insured or proposer and does not have his / her independent sources of income. Children Aged between 1 to 90 Days can be covered if Newborn Baby Benefit is added by payment of additional

premium subject to policy terms and conditions.

Def. 9. Family Floater means a Policy described as such in the Schedule whereunder 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. 10. Insured Person means You and the persons named in the Schedule.

Def. 11. 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. 12. 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. 13. 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. 14. Mental Health Nurse means a person with a diploma or degree in general nursing or diploma or degree in psychiatric nursing recognised by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State

Def. 15. Policy means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure 1 and the 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 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 Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Def. 19. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

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

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

Section B. Benefits

Inpatient Benefits

The following benefits are available to all Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation, Day Care Procedure or Domiciliary Treatment. Any claims made under these benefits will impact eligibility for Cumulative Bonus, Multiplier Benefit and Health Check-up.

We will cover the Medical Expenses for:	We will not cover treatment, costs or expenses for*: *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section C
<p>a. In-patient Treatment: Treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, Cost of Prosthetic and other devices or equipment if implanted internally, medicines, drugs, consumables, diagnostic procedures.</p>	<p>1. Hospitalisation for evaluation, Investigation only 2. Treatment availed outside India 3. Treatment at a healthcare facility which is NOT a Hospital.</p>
<p>b. Pre-hospitalisation Medical expenses for consultations, investigations and medicines incurred upto 30 days before Hospitalisation. c. Post-hospitalisation Medical expenses for consultations, investigations and medicines incurred upto 60 days after discharge from Hospitalisation.</p>	<p>1. Claims which have NOT been admitted under 1a) and 1d) 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required. 3. Expenses not related to the admission and not incidental to the treatment for which the admission has taken place</p>
<p>d. Day Care Procedures</p>	<p>1. Out-patient Treatment 2. Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre</p>

<p>e. Domiciliary Treatment: 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:</p> <ol style="list-style-type: none"> 1. The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or, 2. The patient takes treatment at home on account of non availability of room in a Hospital. 	<p>Treatment of less than 3 days(Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days)</p>						
<p>f. Organ Donor: Medical treatment of the organ donor for harvesting the organ.</p>	<ol style="list-style-type: none"> 1. Claims which have NOT been admitted under 1a). 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses. 						
<p>g. Emergency Ambulance: Expenses incurred on an ambulance in an emergency, subject to lower of actual expenses or Rs. [x] per Hospitalisation</p> <table border="1" data-bbox="60 619 552 754"> <thead> <tr> <th>Sum Insured</th> <th>Amount per hospitalisation (Rs)</th> </tr> </thead> <tbody> <tr> <td>100,000 to 15,00,000</td> <td>2000/-</td> </tr> <tr> <td>20,00,000 to 50,00,000</td> <td>5000/-</td> </tr> </tbody> </table>	Sum Insured	Amount per hospitalisation (Rs)	100,000 to 15,00,000	2000/-	20,00,000 to 50,00,000	5000/-	<ol style="list-style-type: none"> 1. Claims which have NOT been admitted under 1a) and 1 d) 2. A non- emergencies. 3. NON registered healthcare or ambulance service provider ambulances.
Sum Insured	Amount per hospitalisation (Rs)						
100,000 to 15,00,000	2000/-						
20,00,000 to 50,00,000	5000/-						
<p>h. Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as per table below, if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.</p> <table border="1" data-bbox="60 930 552 1094"> <thead> <tr> <th>Sum Insured</th> <th>Limit (Rs)</th> </tr> </thead> <tbody> <tr> <td>100,000 to 5,00,000</td> <td>Rs.500 per day maximum Rs.3,000</td> </tr> <tr> <td>7,00,000 to 50,00,000</td> <td>Rs.800 per day maximum Rs.4,800</td> </tr> </tbody> </table>	Sum Insured	Limit (Rs)	100,000 to 5,00,000	Rs.500 per day maximum Rs.3,000	7,00,000 to 50,00,000	Rs.800 per day maximum Rs.4,800	<ol style="list-style-type: none"> 1. Daily Cash Benefit for days of admission and discharge 2. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 3. Claims which have NOT been admitted under 1a).
Sum Insured	Limit (Rs)						
100,000 to 5,00,000	Rs.500 per day maximum Rs.3,000						
7,00,000 to 50,00,000	Rs.800 per day maximum Rs.4,800						

i. Newborn baby: Medical Expenses for any medically necessary treatment described at 1) a) while the Insured Person (the Newborn baby) is Hospitalised during the Policy Period as an inpatient provided a proposal form is submitted for the insurance of the newborn baby within 90 days after the birth, and We have accepted the same and received the premium sought.

Under this benefit, Coverage for newborn baby will incept from the date, the premium has been received. The coverage is subject to the policy exclusions, terms and conditions.

This Benefit is applicable if Maternity benefit is opted and We have accepted a maternity claim under this Policy.

1. Claims which have NOT been admitted under Maternity Expenses
2. Claims other than Section those available in Section B1

Important terms You should know

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

In-patient Treatment means treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.

Day Care treatments means those medical treatment, and/or surgical procedure (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 a Hospitalisation of more than 24 hours, Treatment normally taken on an Out-patient basis is not included in the scope of this definition.

Out-patient 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 daycare or inpatient.

Medical Practitioner means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his 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.

Shared Accommodation means a Hospital room with two or more patient beds.

Single occupancy or any higher accommodationn type means a Hospital room with only one patient bed.

Newborn Baby means those babies born to You and Your spouse during the Policy Period Aged between 1 day and 90 days.

2. Additional Benefits

Additional Benefit not related to Sum Insured: The following benefit is available to all Insured Persons during the Policy Period. Any claims made under this benefit will not impact eligibility for a Cumulative Bonus, Multiplier Benefit and Health Checkup, if opted.

<p>a. E-Opinion in respect of a Critical Illness We shall arrange and pay for a second opinion from Our panel of Medical Practitioners, if:</p> <ul style="list-style-type: none">• The Insured Person suffers a Critical Illness during the Policy Period; and• He requests an E-opinion; and <p>The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner.</p> <p>“Critical Illness” includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke</p>	<ol style="list-style-type: none">1. More than one claim for this benefit in a Policy Year.2. More than one claim for the same Critical Illness. <p>Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.</p>
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Section C. Waiting Period & Exclusions

1. Standard Waiting Period

All illnesses and treatments shall be covered subject to the waiting periods specified below:

i) 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.

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

ii) Specified disease/procedure waiting period- Code- Excl02

I. Expenses related to the treatment of the listed Conditions, surgeries/treatments as mentioned in the table below 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.

VI. List of specific diseases/procedure:

Sr. No.	Organ / Organ System	Illness	Surgeries
a.	ENT	<ul style="list-style-type: none"> • Sinusitis • Rhinitis • Tonsillitis 	<ul style="list-style-type: none"> • Adenoidectomy • mastoidectomy • tonsillectomy • tympanoplasty • surgery for nasal septum deviation • nasal concha resection
b.	Gynaecological	<ul style="list-style-type: none"> • cysts, polyps including breast lumps • Polycystic ovarian disease • fibroids (fibromyoma) 	<ul style="list-style-type: none"> • Dilatation and curettage (D&C) • Myomectomy for fibroids
c.	Orthopaedic	<ul style="list-style-type: none"> • Non infective arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis 	<ul style="list-style-type: none"> • Surgery for prolapsed inter vertebral disk • Joint replacement surgeries
d.	Gastrointestinal	<ul style="list-style-type: none"> • Calculus diseases of gall bladder including Cholecystitis • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus • Ulcer and erosion of stomach and duodenum • Gastro Esophageal Reflux Disorder (GERD) • All forms of cirrhosis (Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses 	<ul style="list-style-type: none"> • Cholecystectomy • surgery of hernia
e.	Urogenital	<ul style="list-style-type: none"> • Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate 	<ul style="list-style-type: none"> • Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	Cataract	NIL
g.	Others	NIL	Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs/ disciplines whether or not described above)	Internal tumors, cysts, nodules, polyps, skin tumors	NIL

Note: In case a new born is diagnosed with an Internal Congenital Disease related to any of the above listed diseases/procedures, then Specific waiting period (Code – Excl02) for such disease/procedure shall not apply to that new born for life, who are covered under this policy without any break.

iii) 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.

2. Standard General Exclusions

We will not pay for any claim in respect of any Insured Person caused by, arising from or attributable to:

Non-Medical Exclusions	i) Breach of law:Code – Excl10 Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane. ii) Hazardous or Adventure sports Code – Excl09 Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports
Medical Exclusions	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:
c. Surgery to be conducted is upon the advice of the doctor
d. The surgery/procedure conducted should be supported by clinical protocols
e. The member has to be 18 years of age or older and
f. 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 SportsCode – Excl09: Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

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

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

ix) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12

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

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

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

xiii) Unproven Treatments– 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:
g. Any type of contraception, sterilization
h. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

	<p>i. Gestational Surrogacy j. Reversal of sterilization xv) Maternity:Code – Excl18 k. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; l. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.</p>
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3. Specific General Exclusions

Non-Medical Exclusions	<p>i) War or similar situations: Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.</p>
Medical Exclusions	<p>i. 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. ii. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound. iii. Any Insured Person's participation or involvement in naval, military or air force operation. iv. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition"). v. Congenital external diseases, defects or anomalies, vi. Stem cell harvesting. vii. 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). viii. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment). ix. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care. x. 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. xi. Vaccination including inoculation and immunisations (Except post Animal bite treatment), xii. 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. xiii. Treatment taken on Outpatient basis xiv. The provision or fitting of hearing aids, spectacles or contact lenses. xv. 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.</p>

	<p>xvi. 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.</p> <p>vii. 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).</p> <p>viii. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).</p> <p>ix. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.</p> <p>x. 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.</p> <p>xi. Vaccination including inoculation and immunisations (Except post Animal bite treatment),</p> <p>xii. 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.</p> <p>xiii. Treatment taken on Outpatient basis</p> <p>xiv. The provision or fitting of hearing aids, spectacles or contact lenses.</p> <p>xv. 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.</p> <p>xvi. 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.</p> <p>xvii. 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</p> <p>xviii. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.</p> <p>xix. Non-allopathic Treatments</p>
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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. 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.

c. Provision for Penal Interest:

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

of last necessary document.

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

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

d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from

the date of receipt of last necessary document to the date of payment of claim.

d. 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.

e. Moratorium Period

After completion of eight continuous years under this Policy no look back would 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 eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this Policy shall be contestable except for proven fraud & permanent exclusions specified in the policy contract. The Policy would however be subject to all limits, sub limits, co-payments, Deductibles as per the policy contract.

f. 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

g. 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

h. 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.

i. 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.

j. 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.

k. Renewal of Policy

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

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

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

iii. Request for renewal along with requisite premium

shall be received by the Company before the end of the policy period.

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

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

l. 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.

m. 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.

n. 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 Period		2 Year Policy Period	
Length of time Policy in force	% of premium refunded	Length of time Policy in force	% of premium refunded
Upto 1 Month	75.00%	Upto 1 Month	87.50%
Upto 3 Months	50.00%	Upto 3 Months	75.00%
Upto 6 Months	25.00%	Upto 6 Months	62.50%
Exceeding 6 Months	Nil	Upto 12 Months	48.00%
		Upto 15 Months	25.00%
		Upto 18 Months	12.00%
		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.

o. 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

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

p. 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.

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

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

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

2. Specific General Terms

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 during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

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

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.

c. Loadings and Discounts

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 over 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 7days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after getting Your consent and additional premium (if any).

PI Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section C-1 i),ii)& iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/ condition, as applicable. Please visit our nearest branch to refer our underwriting guidelines, if required.

We will provide a family discount of 5% if 2 dependent members are covered and 10% if 3 or more dependent members are covered under a single policy. An additional discount of 7.5% is provided in case the Insured Person is paying 2 years premium in advance as a single premium.

These discounts shall be applicable at inception and renewal of the policy.

d. Notification of Claim

	Treatment, Consultation or Procedure:	HDFC ERGO General Insurance Company must be notified:
i.	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii.	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency:	Within 24 hours of the Insured Person's admission to Hospital.

e. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	Notice period for the Insured Person to take advantage of the cashless service*: *Written notice must be accompanied by full particulars.
i.	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.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii.	Any treatment, consultation or procedure for which a claim may be made 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 of the start of the Insured Person's Hospitalisation.

f. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with any documentation, medical records and information We may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the either of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. 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 with detailed breakup of charges (including but not limited to pharmacy purchase bill,

consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

- iii) Original payment receipts
- iv) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
- v) Discharge Summary containing details of, Date of admission and discharge, detailed clinical history, detailed past history, procedure details and details of treatment taken
- vi) Invoice/Sticker of the Implants.
- vii) A precise diagnosis of the treatment for which a claim is made.
- viii) A detailed list of the individual medical services and treatments provided and a unit price for each.
- ix) 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 Medical Practitioner's invoice.

- x) Obstetric history/ Antenatal card
- xi) Previous treatment record along with reports, if any
- xii) Indoor case papers
- xiii) Treating doctors certificate regarding the duration & etiology
- xiv) MLC/ FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent, in case of Accidental injury

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.

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

g. 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 have 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, We will make payment to the Nominee (as named in the Schedule). The assignment of benefits payable under this Policy shall be subject to applicable law.

iii) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

iv) 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.

h. Non-Disclosure or Misrepresentation:

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

a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule ; and

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

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

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

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

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

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

i. 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.

j. 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 or entity is authorised to receive any notice on Our behalf unless explicitly stated in writing by Us.

k. 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. Others

I. Claim Related Information

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

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, 1st 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, Sonapat 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
<p>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</p>	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
<p>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</p>	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonapat and Bahudurgarh
<p>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</p>	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
<p>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</p>	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
<p>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</p>	Rajasthan.
<p>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</p>	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
<p>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</p>	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
<p>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</p>	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratappgarh, Jaunpur, Varanasi, Gaziipur, 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

<p>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</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane</p>
<p>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</p>	<p>State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanoj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>
<p>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</p>	<p>Bihar, Jharkhand.</p>
<p>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</p>	<p>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</p>

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

Annexure I - List of Non-Medical Expenses

S. No.	Item
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

S. No.	Item
35	Oxygen Cylinder (For Usage outside 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	Trolley Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety