HDFC ERGO General Insurance Company Limited
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Energy, Policy

Suitability:

a) This policy covers persons in the age group 18 years to 65 years. The maximum entry age is restricted upto 65 years.

b) There is no maximum cover ceasing age in this policy.

c) This Policy offers cover to individuals with Type 1 Diabetes, Type 2 Diabetes Mellitus, Impaired Fasting Glucose (IFG), Impaired Glucose Tolerance (IGT) and/or Hypertension.

d) The policy will be issued for a period 1 year.

e) This policy can be issued to an individual only on individual Sum Insured basis.

f) There will be no general waiting period of 30 days applicable in this product.

Sum Insured: Offered are Rs. 200,000; 300,000; 500,000; 10,00,000; 15,00,000; 20,00,000; 25,00,000; 50,00,000.

Salient Features & Benefits:

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.
a. In-Patient Treatment Treatment costs where Insured Person has to stay in a Hospital for more than 24 hours. This includes • Hospital room rent or boarding • Nursing • Intensive Care Unit • Medical Practitioners (Fees) • Anaesthesia • Blood • Oxygen • Operation theatre • Surgical appliances • Medicines, drugs & consumables • Diagnostic procedures • Cost of prosthetic and other devices or equipment if	1. Treatment availed outside India 2. Treatment at a healthcare facility which is NOT a Hospital. 3. Treatment for which hospitalization is not necessary
b. Pre-Hospitalization Medical expenses for consultations, investigations and medicines incurred upto 30 days before Hospitalisation. c. Post-Hospitalization Medical expenses for consultations, investigations and medicines incurred upto 60 days after discharge from Hospitalisation.	1. Claims which have NOT been admitted under In-patient Treatment and Day care procedures. 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
d. Day Care Procedures Medical treatment, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre for less than 24 hours because of technological advancement, which would have otherwise required a hospitalisation of more than 24 hours.	1. Out-Patient Treatment 2. Admission for the purpose of only administration of any drug/ medication/formulation other than cancer chemotherapy. 3. Treatment at a healthcare facility which is NOT a Hospital
e. Organ Donor Medical treatment of the organ donor for harvesting the organ i.e. including surgery to remove organs from a donor in the case of transplant surgery	1. Claims which have NOT been admitted under In-patient Treatment. 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
f. Ambulance Cover Expenses incurred on an ambulance in an emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under In-patient Treatment and Day care procedures. 2. Ambulance services of NON registered healthcare or ambulance service provider.
g. Shared Accommodation Benefit If the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital, Section 3 B xxxi) of Policy wordings will be waived off.	

h. Restore benefit Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, cumulative bonus and Restore sum insured) will be available to the insured person for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the cumulative bonus (if applicable). Conditions for Restore benefit: 1. The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1. 2. The Sum Insured will be restored only once in a Policy Year. 3. If the restored sum insured is not utilised in a policy year, it shall not be carried forward to any subsequent policy year.	
i. HbA1C Checkup Benefit Under this benefit, we will reimburse an amount of up to INR 750 on an each claim towards the expenses of HbA1C checkup on submission of original payment receipt to us subject to 1. The date of tests should be in the Policy period. 2. A maximum of two claims can be made in a Policy year. 3. A minimum of 3 months gap should be there between the two tests 4. In Gold variant, HbA1C checkups done as part of wellness benefit (Section 4.I of Policy Wordings) will not be considered for this benefit.	

Co-payment

If opted and mentioned on the Policy Schedule that a Co-payment is effective, and a claim has been admitted under benefits In-patient Treatment, Pre & Post Hospitalisation Expenses, Day Care Procedures, Organ Donor, Shared Accommodation benefit and Ambulance Cover then, the insured person shall bear 20% of the eligible claim amount payable under the Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

Wellness Programme for Diabetes and Hypertension

Variant 1. Silver Plan

a) To avail Wellness Benefit You may choose to undergo a medical check-up twice in a Policy Year as per grid below at a diagnostic center which is approved by Us. Please note that the costs incurred for these tests will not be borne by Us.

Medical check-up reports have to be submitted to Us in time as per below defined timelines. Any reports submitted after these timelines will not be accepted/considered for wellness benefit.

Period	Diagnostic Tests
Half yearly check-up	HbA1c, Blood pressure Monitoring, BMI, Diabetologist/Cardiologist Consultation
Annual check-up	HbA1c, SMA 12, Total Cholesterol : HDL Cholesterol, ECG, Blood pressure Monitoring, BMI, Diabetologist Consultation/ General Practitioner

SMA 12 - FBS, Total Cholesterol, Creatinine, High-density lipoprotein (HDL) , Low-density lipoprotein (LDL), Triglycerides (TG), Total Protein, Serum Albumin, Gamma-glutamyltransferase (GGT), serum glutamic oxaloacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT), Billirubin

Timelines for submitting the Medical Check-up reports:

Medical Check-up	Reports should be submitted in
Half yearly check-up	4th or 5th months of the policy year
Annual check-up	8th or 9th months of the policy year

b) Based on medical check-up results incentive points would be calculated as per table below, this shall be the basis for deciding appropriate level of reduction in renewal premiums.

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Examination Type	Reading	Points
HbA1c (%) – Half Yearly Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 – 8.00	1
HbA1c (%) – Annual Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 - 8.00	1
Blood Pressure – Half Yearly Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Blood Pressure - Annual Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Body Mass Index (BMI) - Annual Examination	18.00 – 23.00	5
	23.01 – 27.49	2
	27.50 - 34	1
Total Cholesterol : HDL Cholesterol ratio	upto 4.0	2
	4.01 to 5.00	1
Diagnostic test undertaken	Both (Annual + Half Yearly)	3
	Either (Annual or Half Yearly)	1
Diabetologist consultation/General Practitioner	One Visit	2

c) On the completion of all the above stated medical check- ups during the policy year and based on the findings, We may decide to
   a. continue with the published premium, or
   b. charge a reduced premium after applying Wellness discount if earned based on the incentive points mentioned in the above table

Variant 2. Gold Plan

a) We will conduct Your medical check-up twice in a Policy Period as per grid below.

Period	Diagnostic Tests
Half yearly check-up	HbA1c, Blood pressure Monitoring, BMI, Diabetologist/ Consultation
Annual check-up	HbA1c, SMA 12, Total Cholesterol : HDL Cholesterol, ECG, Blood pressure Monitoring, BMI, Diabetologist Consultation/ General Practitioner

SMA 12 - FBS, Total Cholesterol, Creatinine, High-density lipoprotein (HDL) , Low-density lipoprotein (LDL), Triglycerides (TG), Total Protein, Serum Albumin, Gamma-glutamyltransferase (GGT), serum glutamic oxaloacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT), Billirubin

b) The medical check-up shall be conducted by empanelled medical centre and the cost of the same shall be borne by Us. If You choose to undertake medical check-up from a diagnostic center which is approved by Us, We will reimburse upto Rs.2000/- against actual diagnostic bill and You shall provide Us with medical check-up reports in time during Policy Period as per below defined timelines. Any reports submitted after these timelines will not be accepted/considered for wellness benefit.

Timelines for submitting the Medical Check-up reports:

Medical Check-up	Reports should be submitted in
Half yearly check-up	4th or 5th months of the policy year
Annual check-up	8th or 9th months of the policy year

c) We will not reimburse any amount in lieu of the medical check-up, if You choose not to undergo any of the medical checkups.

d) We shall obtain and retain Your medical reports. A copy of the medical check-up reports shall be sent to You for your reference.

e) Based on medical check-up results incentive points would be calculated as per table below, this shall be the basis for deciding appropriate level

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of reduction in renewal premiums.

Examination Type	Reading	Points
HbA1c (%) – Half Yearly Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 – 8.00	1
HbA1c (%) – Annual Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 - 8.00	1
Blood Pressure – Half Yearly Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Blood Pressure - Annual Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Body Mass Index (BMI) - Annual Examination	18.00 – 23.00	5
	23.01 – 27.49	2
	27.50 - 34	1
Total Cholesterol : HDL Cholesterol ratio	upto 4.0	2
	4.01 to 5.00	1
Diagnostic test undertaken	Both (Annual + Half Yearly)	3
	Either (Annual or Half Yearly)	1
Diabetologist consultation/General Practitioner	One Visit	2

f) On the completion of all the above stated medical check- ups during the policy year and based on the findings, We may decide to
   i. continue with the published premium, or
   ii. charge a reduced premium after applying Wellness discount if earned based on the incentive points mentioned in the above table.

Wellness Benefit

a) The appropriate level of discount in renewal premium and renewal incentive would be computed as per below table. Our decision in this regard shall be final and binding on the policyholder.

Points Earned	Discount	Renewal Incentive
29-32	25% discount on renewal premium	Reimbursement upto 25% of renewal premium towards expenses incurred on health care.
25-28	20% discount on renewal premium	Reimbursement upto 20% of renewal premium towards expenses incurred on health care.
16-24	10% discount on renewal premium	Reimbursement upto 10% of renewal premium towards expenses incurred on health care
8-15	5% discount on renewal premium	Reimbursement upto 5% of renewal premium towards expenses incurred on health care
Less than 8	No discount	No Reward

i. Reimbursement under renewal incentive can be claimed once during the Policy Period on submission of original bills or proof of such expenses incurred during the Policy Period on the health of the Insured Person.

ii. Reimbursement can be claimed for the below mentioned health care expenses for Insured Person under the Policy.
   1. Consultation charges
   2. Medicines and drugs
   3. Diagnostic expenses
   4. Dental expenses
   5. Other miscellaneous Medical Expenses not covered under any medical insurance

iii. We will not carry forward any un-claimed amount on subsequent renewal of policy with Us.

b) The revised premium and renewal incentive as per clause a) above shall be applicable only for the following Policy Year onwards and shall be reassessed at the end of each Policy Year.

Cumulative Bonus

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a. A 10% cumulative bonus will be applied on the base Sum Insured for next policy year under the Policy after every CLAIM FREE Policy Year, provided that the Policy is renewed with Us without a break. The maximum cumulative bonus shall not exceed 100% of the Sum Insured in any Policy Year

b. If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the cumulative bonus by 10% of the Sum Insured. There will be no impact on the Inpatient Sum Insured, only the accrued cumulative bonus will be decreased

Key Definitions:

- **A Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage o f the admissible costs. A co-payment does not reduce the sum insured..

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.

Migration:

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

For Detailed Guidelines on Migration, kindly refer the link

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

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;

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.

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.

Exclusions:

Waiting Period

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

i) Specified disease/procedure waiting period- Code- Excl02
   a. 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

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claims arising due to an Accident.

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

c. If any of the specified disease/procedure falls under the waiting period specified for Pre-existing diseases, then the longer of the two waiting periods shall apply.

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

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

List of specific diseases/procedure:

Sl No	Organ / Organ System	Illness	Treatment/Surgeries
a.	Ear, Nose and Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
b.	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
c.	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
d.	Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia
e.	Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	• Cataract • Retinal detachment • Glaucoma	NIL
g.	Others	NIL	• Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs whether or not described above)	Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc.	NIL

ii) Pre-existing Diseases – Code Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.

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

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

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d) Coverage under the Policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

Any condition or illness, complication or ailment arising out of or connected to the below mentioned conditions shall not be considered as part of this waiting period.

a. Type 2 Diabetes Mellitus

b. Impaired Fasting Glucose (IFG)

c. Impaired Glucose Tolerance (IGT)

d. Type 1 Diabetes

e. Hypertension

General exclusions

We will not pay in event of:

We will not pay for any claim for arising from attributable to:

Non Medical Exclusions	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. ii) **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. iii) Intentional self-injury or attempted suicide while sane or insane. iv) **Hazardous or Adventure sports: Code – Excl09** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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Medical Exclusions	v) **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. vi) **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. vii) **Obesity/Weight control:** Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: a. Surgery to be conducted is upon the advice of the doctor b. The surgery/procedure conducted should be supported by clinical protocols c. The member has to be 18 years of age or older and d. Body Mass Index (BMI) i. Greater than or equal to 40 or, ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: 1. Obesity related cardiomyopathy 2. coronary heart disease 3. severe sleep apnoea 4. uncontrolled type2 diabetes viii) **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. ix) **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. x) **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. xi) **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. xii) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12 xiii) 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 xiv) 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 xv) Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. Code – Excl15 xvi) **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 xvii) **Sterility and Infertility** –Code – Excl17 -Expenses related to sterility and infertility. This includes: a. Any type of contraception, sterilization b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI c. Gestational Surrogacy d. Reversal of sterilization

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Medical Exclusions	xviii) **Maternity:Code** – Excl18 a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period. xix) 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. xx) Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound. xxi) Any **Insured Person's** participation or involvement in naval, military or air force operation. xxii) Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition"). xxiii) Congenital external diseases, defects or anomalies, xxiv) Stem cell harvesting, or growth hormone therapy. xxv) **Dental Treatment** and surgery of any kind, unless requiring **Hospitalization**. xxvi) Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities). xxvii) Circumcisions (unless necessitated by **Illness or Injury** and forming part of treatment). xxviii) Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care. xxix) Other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. xxx) Vaccination including inoculation and immunisations (Except post Animal bite treatment), xxxi) **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. xxxii) Treatment taken on Outpatient basis xxxiii) The provision or fitting of hearing aids, spectacles or contact lenses. xxxiv) 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. xxxv) 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. 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 xxxvi) Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

Claim Procedure:

Specified Third Party Administrator (TPA) licensed by IRDA will process all claims under this policy on behalf of HDFC ERGO General Insurance Company Limited. The final decision on any claim solely rests with HDFC ERGO General Insurance Company Limited.

Intimation & Assistance - Please contact our designated TPA atleast 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact our TPA within 24 hours of the event.

Procedure for Reimbursement of Medical Expenses –

- Our TPA must be informed no later than 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/documents mentioned therein to your designated TPA within 15 days of the occurrence of the Incident. * Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by you, the TPA will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents, your designated TPA will send the admissible amount, along with a settlement statement within 30 days.
- The payment will be made in the name of the proposer.

  Note: Payment will only be made for items covered under your policy and upto the limits therein.

Procedure to avail Cashless facility -

- For any emergency Hospitalisation, your designated TPA must be informed no later than 24 hours after hospitalization.
- For any planned hospitalization, kindly seek cashless authorization from your designated TPA atleast 48 hours prior to the hospitalization.
- TPA will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents.

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- Please pay the non-medical and expenses not covered to the hospital prior to the discharge.
- In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours.

Note:

- Insured person is entitled for cashless coverage only in our empanelled hospitals.
- Please refer to the list of empanelled hospitals on our website or the list provided along with Policy kit or call us on our Customer care at 022 6234 6234 / 0120 6234 6234.
- Rejection of cashless facility in no way indicates rejection of the claim. You can approach HDFC ERGO General Insurance Company Limited to settle Your claim by following the "Procedure for Reimbursement of Medical Expenses" as stated above.

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.

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.

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.

Tax Benefit:

- The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.
- Income tax rules are subject to change.

Requirement:

- Completed proposal form

Pre- Acceptance Medical Test:

- Pre-Policy Checkup at our network would be required for all proposals. We will reimburse 100% of the expenses incurred per insured person on the acceptance of the proposal. The medical reports are valid for a period of 30 days from the date of Pre-Policy Checkup.

Pre-policy check up Grid:

Age\SI	**Rs. 200,000; 300,000; 500,000, 10,00,000, 15,00,000, 20,00,000, 25,00,000 & 50,00,000**
18 – 45 Year	Medical examination report, HbA1c, Urine micro albumin, Total Cholesterol, Total Protein, SGOT, Serum Creatinine, Tread Mill Test
> 45 Years	Medical examination report, Tread mill test or ECG with 2D ECHO, Lipids, Serum Creatinine, Liver function test, Ultrasonogram Abd, HbA1C, Urine micro albumin
ME = Medical Examination (Report), FBS = Fasting Blood Sugar, Lipids = Lipid Profile, Sr Creatinine = Serum Creatinine, PSA = Prostate Specific antigen, RUA = Routine Urine Examination, TMT = Treadmill Test, USG = Ultrasonogram, SGOT – Serum Glutamic Oxaloacetic Transaminase, HbA1c – Glycoslated Hb, Total Proteins = Serum total protein, Microalbuminurea = Urine Albumin	

Loading

- We may apply a risk loading on the premium payable (based on the declarations made in the proposal form and the health status of the persons proposed for insurance) at the Commencement Date or on any renewal of the Policy with Us or on the receipt of a request for enhancing the Sum Insured. The maximum risk loading applicable for an individual will not exceed 100% per diagnosis / medical condition and an overall risk loading

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of 150% per individual. 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 not apply any additional loading on your policy premium at renewal based on claim experience.
- We will send You the applicable risk loading or exclusion in writing. You shall give Us Your consent and the additional premium (if any), within 7 days of the issuance of Our letter. If You neither accept Our letter nor revert to Us within 7 days, We will cancel Your application and refund the premium paid within the next 7 days. We will issue Policy only after getting Your consent.

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 2 A i),ii),iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

Cancellation

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

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

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

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

Renewability

- There shall be no cover ceasing age under this policy.

Premium Rates:

- The premium under individual coverage will be charged on the completed age of the individual insured member.
- The premium for the policy will remain the same for the Policy Period mentioned in the policy schedule.
- Please note that your premium at renewal may change due to a change in your age or changes in the applicable tax rate.

Premium payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 7 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable. This provision will not apply to claims arising under Wellness benefit and HbA1C Checkup benefit.

The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Gross Premium Tables (Exclusive of Taxes)

Silver Plan (Base Module)

A. No Copayment

Age Band	200,000	300,000	500,000	1,000,000	1,500,000	2,000,000	2,500,000	5,000,000
18-35	5,642	6,973	9,697	11,980	14,360	17,312	18,789	24,157
36-45	6,733	8,195	12,305	15,200	18,220	21,965	23,838	30,648
46-50	10,302	12,123	16,923	20,906	25,057	30,210	32,785	42,152
51-55	12,510	15,062	21,867	27,012	32,376	39,034	42,363	54,465
56-60	16,150	19,194	25,670	31,711	38,008	45,823	49,731	63,941
61-65	22,163	26,898	36,497	45,085	54,039	65,150	70,704	90,906

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No.146. CIN: U66030MH2007PLC177117. Registered & Corporate Office: 1st Floor, HDFC House, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400 020. For more details on the risk factors, terms and conditions, please read the policy document carefully before concluding a sale. Trade Logo displayed above belongs to HDFC Ltd and ERGO International AG and used by the Company under license. UIN: Energy – HDHHLIP21345V042021

66-70	29,695	36,229	49,487	61,132	73,274	88,340	95,874	123,266
71-75	35,334	43,468	60,159	74,316	89,076	107,391	116,549	149,848
76-80	45,886	56,448	78,273	96,692	115,896	139,725	151,639	194,964
>80	55,559	68,349	94,997	117,353	140,660	169,581	184,041	236,625

B. 20% Copayment

Age Band	200,000	300,000	500,000	1,000,000	1,500,000	2,000,000	2,500,000	5,000,000
18-35	4,597	5,632	7,785	9,590	11,495	13,858	15,041	19,338
36-45	5,521	6,645	9,897	12,174	14,592	17,592	19,092	24,547
46-50	8,486	9,860	13,633	16,751	20,078	24,206	26,270	33,775
51-55	10,339	12,279	17,637	21,652	25,952	31,289	33,957	43,658
56-60	13,383	15,678	20,726	25,426	30,475	36,742	39,875	51,269
61-65	18,406	22,007	29,495	36,162	43,344	52,256	56,711	72,915
66-70	24,708	29,680	40,025	49,046	58,787	70,874	76,919	98,895
71-75	29,448	35,655	48,691	59,637	71,482	86,179	93,528	120,250
76-80	38,296	46,352	63,393	77,612	93,026	112,153	121,716	156,491
>80	46,430	56,178	76,983	94,217	112,928	136,148	147,757	189,974

Gold Plan

A. No Copayment

Age Band	200,000	300,000	500,000	1,000,000	1,500,000	2,000,000	2,500,000	5,000,000
18-35	10,642	11,973	14,697	16,980	19,360	22,312	23,789	29,157
36-45	11,733	13,195	17,305	20,200	23,220	26,965	28,838	35,648
46-50	15,302	17,123	21,923	25,906	30,057	35,210	37,785	47,152
51-55	17,510	20,062	26,867	32,012	37,376	44,034	47,363	59,465
56-60	21,150	24,194	30,670	36,711	43,008	50,823	54,731	68,941
61-65	27,163	31,898	41,497	50,085	59,039	70,150	75,704	95,906
66-70	34,695	41,229	54,487	66,132	78,274	93,340	100,874	128,266
71-75	40,334	48,468	65,159	79,316	94,076	112,391	121,549	154,848
76-80	50,886	61,448	83,273	101,692	120,896	144,725	156,639	199,964
>80	60,559	73,349	99,997	122,353	145,660	174,581	189,041	241,625

B. 20% Copayment

Age Band	200,000	300,000	500,000	1,000,000	1,500,000	2,000,000	2,500,000	5,000,000
18-35	9,597	10,632	12,785	14,590	16,495	18,858	20,041	24,338
36-45	10,521	11,645	14,897	17,174	19,592	22,592	24,092	29,547
46-50	13,486	14,860	18,633	21,751	25,078	29,206	31,270	38,775
51-55	15,339	17,279	22,637	26,652	30,952	36,289	38,957	48,658
56-60	18,383	20,678	25,726	30,426	35,475	41,742	44,875	56,269
61-65	23,406	27,007	34,495	41,162	48,344	57,256	61,711	77,915
66-70	29,708	34,680	45,025	54,046	63,787	75,874	81,919	103,895
71-75	34,448	40,655	53,691	64,637	76,482	91,179	98,528	125,250
76-80	43,296	51,352	68,393	82,612	98,026	117,153	126,716	161,491
>80	51,430	61,178	81,983	99,217	117,928	141,148	152,757	194,974

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Premium payment Options

Sr. No	Premium Payment Option	Installment as % of annual gross premium
1	Half Yearly	51.50%
2	Quarterly	26.25%

Section 41 of Insurance Act 1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

IRDA REGULATION NO 12: This policy is subject to regulation 12 of IRDAI(Protection of Policyholders' Interests) Regulations, 2017.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDA.

Disclaimer:

This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification.

Schedule of Benefits

Gold Plan:

Sum Insured – (Rs. In Lakhs)	2.00, 3.00, 5.00, 10.00, 20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered
1 b) Pre-hospitalization	Covered
1 c) Post-hospitalization	Covered
1 d) Day Care Procedures	All Day Care Procedures Covered
1 e) Organ Donor	Covered
1 f) Ambulance Cover	Upto Rs.2000 per hospitalisation
1 g) Shared Accommodation Benefit	Covered
1 h) HbA1C Checkup Benefit	Covered
1 i) Restore Benefit	Covered
2 Wellness Programme for Diabetes and Hypertension	Covered

Silver Plan:

Sum Insured – (Rs. In Lakhs)	2.00, 3.00, 5.00, 10.00, 20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered
1 b) Pre-hospitalization	Covered
1 c) Post-hospitalization	Covered
1 d) Day Care Procedures	All Day Care Procedures Covered
1 e) Organ Donor	Covered
1 f) Ambulance Cover	Upto Rs.2000 per hospitalisation
1 g) Shared Accommodation Benefit	Covered
1 h) HbA1C Checkup Benefit	Covered
1 i) Restore Benefit	Covered
2 Wellness Programme for Diabetes and Hypertension	Covered

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