HDFC Group Health Insurance

Prospectus

Key features of the policy:

1. Entry age limit of 65 years with lifetime renewal
2. Various optional covers available such as Hospital Cash, Cumulative Bonus etc.
3. 100% Sum Insured Restore Benefit available.
4. PED coverage after 36 months.
5. Option to pay premium in monthly, quarterly and half-yearly installments

Section A. Gold Plan

We will pay under below listed Covers on **Medically Necessary Hospitalization** of an **Insured Person** due to **Illness** or **Injury** sustained or contracted during the **Period of Insurance** subject to terms and conditions as listed below.

1. In-Patient Hospitalization

i. **Room Rent** and boarding charges up to 1% of Base **Sum Insured** , subject to a maximum limit of INR 3000 per day
ii. **Intensive Care Unit** charges up to 2% of Base **Sum Insured**
iii. Consultation fees & Nursing charges
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
v. Medicines, drugs and consumables
vi. Diagnostic procedures
vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

a. **Special Conditions**

i. **Room Rent & Proportionate deduction:** In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/payment of **Room Rent** charges including all **Associated Medical Expenses** incurred at **Hospital** shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of **Room Rent** charges. This condition is not applicable in respect of **Hospitals** where differential billing for **Associated Medical Expenses** is not followed based on Room category.

ii. **Mental Illness**

The Coverage for Mental illness is applicable if done in **Mental Health Establishment** and is subject to the provisions contained in the Mental Health Care Act, 2017, as amended from time to time and other applicable laws and Regulations.

2. Pre-Hospitalization Medical Expenses Cover

We will pay for the Pre-Hospitalization **Medical Expenses** incurred during the 60 days immediately before **Hospitalization** of an **Insured Person.**

3. Post-Hospitalization Medical Expenses Cover

We will pay for the Post-Hospitalization **Medical Expenses** incurred upto 90 days from the date **Insured Person** is discharged from **Hospital.**

4. Day Care Procedures

We will pay for the **Medical Expenses** under Section A1 on **Hospitalization** of **Insured Person** in **Hospital** or **Day Care Centre** for **Day Care Treatment.**

5. Domiciliary Hospitalization

We will pay the **Medical Expenses** incurred on **Domiciliary Hospitalization** of the **Insured Person** presecribed by treating **Medical Practitioner.**

6. Road Ambulance Cover

For each admissible Claim under Section A1 and A4, **We** will pay for expenses incurred on Road Ambulance Services if **Insured Person** is required;

i. to be transferred to the nearest **Hospital** following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)
ii. or from one **Hospital** to another **Hospital**
iii. or from **Hospital** to Home (within same City) following **Hospitalization**

7. Organ Donor Expenses

We will pay **Medical Expenses** covered under Section A1 towards organ donor's **Hospitalization** for harvesting of the donated organ where an **Insured Person** is the recipient subject to condition that;

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/or Regulations.
ii. **Hospitalization** Claim under Section A1 is admissible under the coverage for the **Insured Person**
iii. The Organ Donor's **Pre-Hospitalization** and **Post-Hospitalization Medical Expenses** are excluded under the **Policy**.
iv. Any other **Medical Expenses** or **Hospitalization** consequent to the harvesting is excluded under the **Policy**.

Section B. Platinum Plan

We will pay under below listed Covers on **Medically Necessary Hospitalization** of an **Insured Person** due to **Illness** or **Injury** sustained or contracted during the **Period of Insurance** subject to terms and conditions as listed below.

1. In-Patient Hospitalization

i. **Room Rent** and boarding charges
ii. **Intensive Care Unit** charges
iii. Consultation fees & Nursing charges
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
v. Medicines, drugs and consumables
vi. Diagnostic procedures
vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

a. **Special Conditions**

i. **Mental Illness**

The Coverage for Mental illness is applicable if done in **Mental Health Establishment** and is subject to the provisions contained in the Mental Health Care Act, 2017, as amended from time to time and other applicable laws and Regulations.

2. Pre-Hospitalization Medical Expenses cover

We will pay for the **Pre-Hospitalization Medical Expenses** incurred during the 60 days immediately before **Hospitalization** of an **Insured Person**.

3. Post-Hospitalization Medical Expenses cover

We will pay for the **Post- Hospitalization Medical Expenses** incurred upto 180 days from the date **Insured Person** is discharged from **Hospital.**

4. Day Care Procedures

We will pay for the **Medical Expenses** under Section B1 on **Hospitalization** of **Insured Person** in **Hospital** or **Day Care Centre** for **Day Care Treatment.**

5. Domiciliary Hospitalization

We will pay the **Medical Expenses** incurred on **Domiciliary Hospitalization** of the **Insured Person** presecribed by treating **Medical Practitioner.**

6. Road Ambulance Cover

For each admissible Claim under Section B1 and B4, **We** will pay for expenses incurred on Road Ambulance Services if **Insured Person** is required;

i. to be transferred to the nearest **Hospital** following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)
ii. or from one **Hospital** to another **Hospital**
iii. or from **Hospital** to Home (within same City) following **Hospitalization**

7. Organ Donor Expenses

We will pay **Medical Expenses** covered under Section B1 towards organ donor's **Hospitalization** for harvesting of the donated organ where an **Insured Person** is the recipient subject to condition that;

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/or Regulations.
ii. **Hospitalization** Claim under Section B1 is admissible under the coverage for the **Insured Person**
iii. The Organ Donor's **Pre-Hospitalization** and **Post-Hospitalization Medical Expenses** are excluded under the **Policy**.
iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the **Policy**.

Section C. Optional Covers

Insuring Clause

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that **We** will pay/restrict the expenses under below listed Covers subject to waiting periods and limits as specified on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.

Subject to otherwise all other terms, conditions, exclusions and waiting periods applicable to the **Policy**.

These Covers are optional and applicable only if opted for and upto the **Sum Insured** or limits mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.

1. Preventive Health Check Up

We will indemnify the **Insured Person** towards the cost of **Preventive Health Check – Up,** up to the limit mentioned on the Schedule of Coverage in the **Policy Schedule**/Certifiate of Insurance.

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Other terms and Conditions applicable to this Coverage

- The Coverage will be applicable as per the eligibility as mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.
- In case of Annual Eligibility, the percentage and limit will be calculated on expiring Coverage **Sum Insured** and will be only applicable to **Insured Person** covered under expiring Coverage, subject to no claim under Base Coverage.
- In case of Eligibility at the end of each block of continuous years (as mentioned on the Schedule of Coverage), the percentage and limit will be calculated on Average **Sum Insured** during block of three years and will be only applicable to **Insured Person** covered for all previous 3 years.
- Claim under this Cover does not impact the **Sum Insured** or the eligibility for **Cumulative Bonus.**

- The test reports received under this Coverage will not be utilized for re-underwriting the expiring coverage of I**nsured Person**

2. Cumulative Bonus

On each continuous **Renewal** of the Coverage with **Us**, **We** will apply 10% of Base **Sum Insured** irrespective of any claims and shall be available under the Renewed Policy as specified in the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance under expiring policy year as **Cumulative Bonus** in the Coverage provided that;

i. **Cumulative Bonus** can be accumulated upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.
ii. **Cumulative Bonus** applied will be applicable only to Insured Person(s) covered under the expiring policy year and who continue to remain insured on Renewal.
iii. In policies with a 2/3 year Policy Period, the application of above guidelines of **Cumulative Bonus** shall be post completion of each policy year.
iv. Portability/migration benefit will be offered to the extent of sum of previous sum insured and accrued **Cumulative bonus**, portability/migration benefit shall not apply to any other additional increased Sum Insured.
v. The applicable **Cumulative Bonus** shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy

3. Hospital Cash

If **Insured Person** contracts **Illness** or sustains **Injury** during **Period of Insurance,** which results in **Medically Necessary**;

i. **Hospitalization**
ii. Domiciliary **Hospitalization**
iii. **Hospitalization** for **Alternative Treatments**

of an **Insured Person** within India, **We** will pay per day **Sum Insured** as specified on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance subject to maximum number of benefit days for each continuous and completed period of 24 hours of such **Hospitalization**.

4. Restore Benefit

Instant addition of 100% Base **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 (Base **Sum Insured**, **Cumulative Bonus** and Restore **Sum Insured**) will be available to all Insured Persons for all claims under the Coverage during the current **Policy Year** and subject to the condition that single claim in a **Policy Year** cannot exceed the sum of Base **Sum Insured** and the **Cumulative Bonus** (if applicable).

Conditions for Restore benefit:

a. The **Sum Insured** will be restored only once in a **Policy Year**.
b. If the Restored **Sum Insured** is not utilized in a **Policy Year**, it will expire.

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

5. Waiting period Modification Option

On availing this option, **Waiting Periods** listed under Section D.I.i shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

All other terms and Conditions of the **Policy** shall remain unaltered.

6. Specific Illness Waiting period Modification Option

On availing this option, **Waiting Periods** listed under Section D.I.ii shall stand modified as mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

All other terms and Conditions of the **Policy** shall remain unaltered.

7. Alternative Treatment

We will pay **Medical Expenses** covered under Section A or B as opted, only on **Medically Necessary In-patient care treatment** of **Insured Person** in **Ayush Hospital** upto the limit mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance for following **Alternative Treatments** prescribed by **Medical Practitioner**:

- Ayurvedic
- Unani
- Siddha
- Homeopathy
- Yoga & Naturopathy

Note : Alternative Treatment is no longer an optional cover. Basis CIR. Ref. IRDAI/HLT/CIR/GDL/31/01/2024 issued by IRDAI, all Insured Persons shall be covered by default for In-patient care expenses under this cover upto Sum Insured of Gold Plan or Platinum Plan as opted.

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

Section D. What is not Covered

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

I. Waiting Periods

Claims under the **Policy** are covered subject to Waiting Period as specified below:

i) **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 36 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.
d) Coverage under the **Policy** after the expiry of 36 months for any **pre-existing disease** is subject to the same being declared at the time of application and accepted by Insurer.

ii) **Specified Disease/Procedure waiting period - Code - Excl02**

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

Illnesses

	Non infective Arthritis	Pilonidal sinus
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g.Kidneystone,Urinary Bladder Stone	Benign tumors, cysts, nodules, polyps including breast lumps
Pancreatitis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors
Cataract	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Osteoarthritis and osteoporosis	Fibroids (fibromyoma)	Benign Hyperplasia of Prostate

Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy	Hernia
Dilatation and curettage (D&C)	Nasal concha resection	Surgery for prolapsed inter vertebral disc
Myomectomy for fibroids	Surgery of Genito urinary system	Surgery for varicose veins and varicose ulcers
Surgery on prostate	Cholecystectomy	Surgery for Perianal Abscesses
Hydrocele/Rectocele	Joint replacement surgeries	Surgery for Nasal septum deviation
Ligament, Tendon and Meniscal tear	Hysterectomy	Fissurectomy, Haemorrhoidectomy,

		Fistulectomy, ENT surgeries
Endometriosis	Prolapsed Uterus	Rectal Prolapse
Varicocele	Retinal detachment	Glaucoma
Nasal polypectomy		

iii) **30-day waiting period – Code – Excl03**

a) Expenses related to the treatment of any **Illness** within 30 days from the first **Policy** commencement date shall be excluded except claims arising due to an **Accident**, provided the same are covered.
b) This exclusion shall not, however, apply if the **Insured Person** has continuous coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced **Sum Insured** in the event of granting higher **Sum Insured** subsequently.

II. Permanent Exclusions

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

i. **Investigation & Evaluation:** Code - Excl04
   a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

ii. **Rest Cure, rehabilitation and respite care:** Code – Excl05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. **Obesity/Weight control:** Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the doctor
   b. The surgery/procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI)
      i. Greater than or equal to 40 or,
      ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      iii. Obesity related cardiomyopathy
      iv. coronary heart disease
      v. severe sleep apnoea
      vi. uncontrolled type2 diabetes

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

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

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

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

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

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

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

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

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

xiii. **Unproven Treatments:** Code – Excl16 - 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.

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

   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization

xv. **Maternity:** Code – Excl18

   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

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

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

xviii. Any **Insured Person**'s participation or involvement in naval, military or air force operation.
xix. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
xx. Congenital external diseases, defects or anomalies,
xxi. Stem cell harvesting
xxii. 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).
xxiii. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).
xxiv. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
xxv. 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.
xxvi. Vaccination including inoculation and immunisations (Except post Animal bite treatment),
xxvii. **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 available at www.hdfcergo.com.
xxviii. Treatment taken on Outpatient basis.
xxix. The provision or fitting of hearing aids, spectacles or contact lenses.
xxx. 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.
xxxi. 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.
xxxii. Expenses for Artificial limbs or 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 also available on www.hdfcergo.com.
xxxiii. Any Claim arising due to Non-disclosure of Pre-existing **Illness** or **Material fact** as sought to be declared on the Proposal form.

Section E. Claims Procedure

1. Notification of a Claim

Procedure	Cashless Hospitalization		Reimbursement Claims
	Emergencies	Planned	
Claim Intimation **You** shall intimate the Claims to us through any available mode of communication as specified in the **Policy**, Health Card or our Website			

Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for claim notification	i. The health card issued by **Us** ii. KYC documents iii. The Policy Number iv. Name of the **Policyholder** v. Name and address of **Insured Person** vi. Nature of the **Illness/Injury** and the treatment required vii. Name and address of the attending Medical Practitioner viii. Name of Hospital for admission/treatment ix. Proposed /Actual Date of admission x. MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury).		
Hospital Cash	i. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge ii. First consultation letter from treating Medical Practitioner iii. Certificate from treating Medical Practitioner, specifying the duration and aetiology iv. MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury). v. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), vi. legal heir certificate in case nominee is minor.		
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the **Insured person**(s) iii. Nature of disease/**Illness**/**Injury** iv. Name and address of the attending **Medical Practitioner /Hospital** v. Date of admission & probable date of discharge vi. Approximate Claim Expenses		Not Applicable
	Any other relevant information as required		

Process for pre-authorization	On receipt of duly filled pre authorization form and other details, We may; • Issue the authorization letter specifying the sanctioned amount, limitation, and non-payable items, if applicable Or • Reject the request for pre-authorization specifying reasons for the rejection.	Not Applicable
List of Claim documents	Not Applicable	As enlisted below
Condonation of Delay	If the claim is not notified/ or submitted to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control	

2. List of documents for Reimbursement Claims

i. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by **Hospital**).
ii. Photo ID & Age Proof
iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of **Hospitalization** in any non-network hospital of HDFC ERGO GIC or certificate from **Hospital** authorities providing facilities available including number of beds.
v. Discharge Card / Day Care Summary / Transfer Summary
vi. Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded
vii. Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
viii. All previous consultation papers indicating history and treatment details for current **Illness** and advice for current hospitalization.
ix. All diagnostic reports (including imaging and laboratory) along with prescription by **Medical Practitioner** and invoice / bill with receipt from diagnostic centre
x. All medicine / pharmacy bills along with prescription by **Medical Practitioner**
xi. MLC / FIR Copy – in **Accidental** cases only
xii. History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.
xiii. Copy of Death Summary and copy of Death Certificate (in death claims only)
xiv. Pre and Post-Operative Imaging reports
xv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).
xvi. Invoice for Vaccination and payment receipt

xvii. KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Claimant carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Claimant ***

xviii. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)

xix. Settlement letter(s), copy (-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of Insured Person, the same document reuqirement would be for nominee/legal heir of Insured Person(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility

i. **Cashless facility** can be availed only at **Our Network Provider**. The complete list of **Network Providers** and empanelled Service Providers is available on **Our** website and can be obtained by contacting **Us**.

ii. We reserve the right to modify, add or restrict any **Network Provider** for Cashless Facilities at **Our** sole discretion. The same shall be duly updated on **Our** website. **You** shall check the updated list of **Network Providers** before applying for Cashless Claim.

iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the **Hospitalization**/treatment, including dates**, Hospital** and locations match with the details as per Cashless authorized.

iv. **We** will make payment for the Cashless authorized amount directly to the **Network Provider**.

v. If the claim is not notified to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim

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

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

iii. If requested by **Us,** at **Our** cost, the **Insured Person** must submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and **We/Our** representatives must be permitted to inspect the medical and Hospitalization records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.

iv. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess **Our** liability and quantum in respect of the claim

Section F. General Conditions

1. Entry Age:

Base Cover

Proposer	Adult Dependent	Child/Children

• Minimum Entry Age – 18 Years • Maximum Entry Age – 65 Years	• Minimum Entry Age – 18 Years • Maximum Entry Age - 65 Years	• Minimum Entry Age – 91 days • Maximum Entry Age - 25 years

Optional covers:

Proposer	Adult Dependent	Child/Children
• Minimum Entry Age – 18 Years • Maximum Entry Age – 65 Years	• Minimum Entry Age – 18 Years • Maximum Entry Age - 65 Years	• Minimum Entry Age – 91 days • Maximum Entry Age - 25 years

2. Type of Policy:

Individual and Family Floater

3. Coverage for dependents:

- **Floater Sum Insured Option:** Self, Spouse, Dependent Children* and Dependent Parents.
  * Dependent children: A child is considered a dependent for insurance purposes until his 25th birthday (even if not enrolled in an educational institution) provided he is financially dependent, on the proposer.

4. Policy period

This policy can be issued for 1 year

5. Sum Insured Options

- 1 lac
- 2 lacs
- 3 lacs
- 4 lacs
- 5 lacs
- 7.5 lacs
- 10 lacs
- 15 lacs

- 20 lacs
- 25 lacs
- 50 lacs

6. Sum Insured for Optional Covers

Preventive Health Check Up	1% of Base Sum Insured, max upto INR 2000 during block of 3 years		
	1% of Base Sum Insured, max upto INR 7500 for every claim free year		
Cumulative Bonus	10% max up to 50%	10% max up to 100%	
Hospital Cash	Per day Sum Insured in ₹	500	1000
Restore Benefit	100% of Basic Sum Insured		
Waiting Period Modification Option		2 years	1 year
Specific Illness Waiting Period	1 Year		
Alternative Treatment	10% of Base Sum Insured		
	25% of Base Sum Insured		
	50% of Base Sum Insured		
	100% of Base Sum Insured		

7. Pre-Policy Check Up

The PPC tests required will be as per the below PPC grid. This grid may be subject to change based on the company policy in future & will be guided by our experience

PED/BMI	SI	Upto 55 years	> 55 years
Yes	1-3 Lac	Tele MER followed by PPC (if Required) (Set 2)	Tele MER and PPC (Set 3)
	>4 Lac	Tele MER followed by PPC (if Required) (Set 2)	PPC (Set 3)
NO	1-3 Lac	STP	Tele MER and PPC (Set 2)
	>4 Lac	STP	PPC (Set 2)

Set 1: ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG

Set 2: ME, RUA, CBC, Sr Creatinine, Lipid Profile, SGPT, GGTP, SGOT, HBA1C, ECG, HBsAg, TMT/2D Echo, USG Abdomen & Pelvis, Chest X ray, CEA

Set 3: Set 2, PSA (Males), Pap Smear & Sonomamography (Females), Micro albumin, BUN, Sr Uric Acid, ANA

Guidelines for Pre Policy Check up

- Pre Policy Check-up will be conducted at our **Network provider**
- Where ever Pre Policy Check-up is conducted at our **Network provider**, 100% of the Medical test charges will be reimbursed on acceptance of proposal. In case Customer Insists on a Check-up outside our **Network provider**, 50% of the Medical test charges will be reimbursed on acceptance of Proposal.
- If Proposal is declined post Pre Policy Check-up, 50% of the Medical test charges incurred will be reimbursed
- Medical Reports are considered valid for up to 3 months
- In case of any positive health declaration on the proposal form the relevant medical tests shall be advised in addition to the above grid tests
- In case of any additional tests advised besides the ones mentioned above,100% of the cost incurred on such test will be borne by customer

8. 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 30 day notice by sending an endorsement to **Your** address shown in the **Policy Schedule**/Certificate of Insurance, 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 1 i above.

9. 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**.

10. 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**.

11.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.

12.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**.

13.Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits

14.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**.

15. Geography

This **Policy** only covers Medical Treatment taken within India.

16. Loadings

i. **We** may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.
ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each **Insured Person**
iii. Loadings will be applied from Commencement date of the **Policy** including subsequent **Renewal**(s) with **Us** or on increased **Sum Insured**. We will not apply any additional loading on **Your Policy** premium at **Renewal** based on claim experience in **Your Policy**.
iv. **We** will inform **You** about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the **Policy** only on **Your** acceptance within 15 days of the receipt of such counter offer letter. In case, **You** neither accept the counter offer nor revert to **Us** within 15 days, **We** shall cancel **Your** application and refund the premium paid within next 7 days.

17. Renewal of Policy:

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

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

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

18. Grace Period

i. A **Grace Period** of 30 days is available for Renewal of the Coverage. Any **Illness**, disease or condition contracted during **Grace Period** will not be covered and will be treated as **Pre-existing diseases**.
ii. For **Renewal** received after completion of **Grace Period**, the Coverage would be considered as fresh without any **Renewal** benefits
iii. For Policies on instalment basis, Grace Period is available as given below.

Instalment Premium Option	Grace Period applicable
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

19. 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 30 days from date of receipt of the **Policy** document to review the terms and conditions of the **Policy**, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the **Company** on medical examination of the **Insured Person** and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the **Policy** is exercised by the **Insured Person**, a deduction towards the proportionate risk premium for period of cover **or**
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

20. 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**.

21. Portability

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the **Policy** renewal date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health insurance **Policy** with an Indian General/Health insurer, the proposed

Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Portability**.

22. Endorsements

The following endorsements are permissible during the **Policy Period**:

Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / **Insured Person** (and not the complete name change)
ii. Rectification in gender of the **Insured Person**
iii. Rectification in relationship of the **Insured Person** with the Proposer
iv. Rectification of date of birth of the **Insured Person** (if this does not impact the premium)
v. Change in the correspondence address of the **Insured Person**/Proposer(if this does not impact the premium)
vi. Change in Nominee Details
vii. Change in Height, weight, marital status (if this does not impact the premium)
viii. Change in bank details
ix. Any other non-financial endorsement

Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth
ii. Change in Height, weight
iii. Addition of **Insured Person** (New Born Baby or newly wedded spouse)
iv. Deletion of **Insured Person** on death or Marital separation
v. Any other financial endorsement

The **Policyholder/Insured Person** shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of **Insured person**.

23. Cancellation

i. The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.
ii. Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.
iii. 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.
iv. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s
v. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

24. 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** as mentioned in the table below would be given to pay the instalment premium due for the **Policy.**

Options	Installment Premium Option	Grace Period applicable
Option 1	Half Yearly	30 days
Option 2	Quarterly	30 days
Option 3	Monthly	15 days

ii. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).
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 installments shall immediately become due and payable.
vii. The **Company** has the right to recover and deduct all the pending installments from the claim amount due under the **Policy**.

25.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.

26. 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.

27.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**.

28. Claim Settlement (provision for Penal Interest)

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.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.Disclaimer applicable to **HDFC ERGO Mobile App** and associated services

It is agreed and understood that Our **HDFC ERGO Mobile App** intention is not to provide specific medical advice but rather to provide users with information to better understand their health and their diagnosed disorders. The information is not a substitute for professional medical care by a qualified doctor or other health care professional.

The information provided is general in nature and is not specific to you. You must never rely on any information obtained using this app for any medical diagnosis or recommendation for medical treatment or as an alternative to medical advice from your physician or other professional healthcare provider. If you think you may be suffering from any medical condition you should seek immediate medical attention.

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29. Communication & Notice

Policy and any communication related to the **Policy** shall be sent to through electronic modes or to the address of the Insured as recorded in the **Policy**.

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 punishable with fine which may extend to Ten Lakh Rupees.

IRDAI Regulation no 5 - This policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests).

Annexure I – Plan Chart

Base Hospitalisation	Group Health Product

Cover	Gold Plan	Platinum Plan
In-Patient Hospitalisation	Covered Up-to Sum Insured	Covered Up-to Sum Insured
Room Rent Limit (Per Day)	1% of Base SI, max 3,000	At Actuals
ICU Limit (Per Day)	2% of Base SI	At Actuals
Pre Hospitalisation (Days)	60	60
Post Hospitalisation (Days)	90	180
Day Care Procedures	All Day Care Treatments covered	All Day Care Treatments covered
Domiciliary Treatment	Covered Up-to Sum Insured	Covered Up-to Sum Insured
Organ Donor Expenses	Covered Up-to Sum Insured	Covered Up-to Sum Insured
Ambulance Cover	Upto 2,000/hospitalisation	Upto 2,000/hospitalisation

Optional Covers			
Preventive Health Check Up	1% of Base Sum Insured, max upto INR 2000 during block of 3 years		
	1% of Base Sum Insured, max upto INR 7500 for every claim free year		
Cumulative Bonus	10% max up to 50%	10% max up to 100%	
Hospital Cash	Per day Sum Insured in ₹	500	1000
	Up to maximum number of 30 days		
Restore Benefit	100% of Basic Sum Insured		
Waiting Period Modification Option		*2 years	*1 year
Specific Illness Waiting Period*	1 Year		
Alternative Treatment	10% of Base Sum Insured		
	25% of Base Sum Insured		
	50% of Base Sum Insured		
	100% of Base Sum Insured		

*Only applicable for Sum Insured greater than INR 4 lacs