HDFC ERGO General Insurance Company Limited

Policy Wording

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HDFC ERGO GENERAL INSURANCE

my:health Medisure Classic Insurance

A. PREAMBLE

The Insured named in the Schedule has, by a Proposal, declaration and/or medical reports which shall be the basis of the contract and shall be deemed to be incorporated herein, applied to HDFC ERGO General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth.

Subject to the terms, conditions, exclusions, stipulations and definitions contained herein or endorsed or otherwise expressed hereon, if during the Policy Period, the Insured/Insured Person shall contract any disease or illness or suffer any injury and is required to undergo treatment by way of Hospitalisation in any Hospital/Nursing Home in India (hereinafter called "Hospital") or in case of Domiciliary Hospitalisation upon the advice of a duly qualified Medical Practitioner, the Company agrees to reimburse to the Insured/Insured Person or his/her nominee, expenses related to such treatment by reimbursement of Expenses covered under this Policy, subject to the limits prescribed herein, if any and not exceeding the applicable Sum Insured (including earned Cumulative Bonus, if any) for all claims during such Policy Period.

B. DEFINITIONS

Following words and expressions which are defined to bear the same meaning wherever they appear in this Policy:

"We/Our/Us" means the HDFC ERGO General Insurance Company Limited.

"You/Your/Insured/Insured Person" means the person(s) named as Insured/Insured Person in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

"Accident" is a sudden, unforeseen and involuntary event caused by external and visible and violent means.

"Any one illness" means continuous Period of Illness and it includes relapse with in 45 days from the date of hospitalization at the Hospital/Nursing home where treatment may have been taken.

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

"Cancellation" defines the terms on which the Policy contract can be terminated either by the Insurer or the Insured by giving sufficient notice to other which is not lower than period of 15 days.

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

"External Congenital anomaly" means a condition(s) which is in visible and accessible parts of
the body

"Internal Congenital anomaly" means a condition(s) which is not in visible and accessible part
of the body.

"Co-payment" is a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specific percentage of the admissible Claim amount. A Co-payment is applicable on a claim and does not reduce the Sum Insured.

Condition Precedent: shall mean Policy term or condition upon which the Insurers liability under the Policy is conditional upon.

"Critical Illness" means following disease/illness:

1. **Cancer (of specific severity)**

   A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

   The following are excluded:

   - Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
   - Any skin cancer other than invasive malignant melanoma
   - All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
   - Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
   - Chronic lymphocyctic leukaemia less than RAI stage 3
   - Micro-carcinoma of the bladder
   - All tumours in the presence of HIV infection.

2. **Open Chest CABG**

   The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

   Excluded are: (1) Angioplasty and/or any other intra-arterial procedures (2) any key-hole or laser surgery.

3. **First Heart Attack (of specific severity)**

   The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

   The diagnosis for this will be evidenced by all of the following criteria:

   - A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
   - New characteristic electrocardiogram changes
   - Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

   The following are excluded:

   - Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
   - Other acute Coronary Syndromes
   - Any type of angina pectoris.

4. **Kidney Failure (requiring regular dialysis)**

   End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

5. **Multiple Sclerosis with persisting symptoms**

   The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

   - Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
   - There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and
   - Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

   Other causes of neurological damage such as SLE and HIV are excluded.

6. **Major Organ/Bone Marrow Transplant**

   The actual undergoing of a transplant of:

   - One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   - Human bone marrow using hematopoietic stem cells.

   The undergoing of a transplant has to be confirmed by a specialist Medical

Practitioner.

Coverage includes reimbursement of expenses incurred towards hospitalization of the donor, provided that the

- Organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules,
- Organ donated is for the use of the Insured Person.

Coverage under this section shall not pay for any Pre-Post hospitalization expenses of the donor, donor screening, cost of organ or any other medical treatment for the donor consequent on the harvesting.

The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted.

7. **Stroke (resulting in permanent symptoms)**

Any cerebro-vascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extra-cranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **Aorta Graft Surgery**

The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon.

The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneurysms)
- Angiography (an x-ray of the blood vessels).

9. **Primary Pulmonary Arterial Hypertension**

The first diagnosis of a primary pulmonary hypertension (PPH) which results in elevation of blood pressure in the pulmonary artery with no apparent reason and measures greater than 25 mm Hg at rest or 30 mm Hg during exercise. The diagnosis of the condition to be evidenced by:

- Electrocardiogram or X-Ray and
- Echocardiography
- Pulmonary Function test
- High Resolution Computerized Tomography Scan (HRCT-Chest).

Further diagnosis to be evidenced by Cardiac Catheterization or Pulmonary ateriography in case the above are not sufficient to confirm PPH.

Commencement Date/Inception Date: means the commencement date of this Policy as specified in the Schedule.

Cumulative Bonus: Cumulative Bonus shall mean any increase in Sum Insured granted by Us without an associated increase in Premium.

Contribution: is essentially the right of the Company to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Day Care treatment: refers to 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 due to technological advancement, and
- which would have otherwise required hospitalization of more than 24 hours.
- Treatment taken as an outpatient is not included under the Policy.

Day Care Centre: A Day care centre means any institution established for day care treatment of illness and/or injuries or a medical set up with in a hospital and which has been registered with local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner and must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment
- Has qualified medical practitioner (s) in charge
- Has fully equipped operation theater of its own where surgical procedures are carried out
- Maintains daily record of patients and will make these accessible to the Insurance company's authorized personnel.

Dental treatment: is a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants

Dependents: mean only the family members listed below:

i. Insured's legally married spouse ,

ii. Insured's dependent children – being your children (natural or legally adopted) aged between 3 months and 23 years, who is/are financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

iii. Insured's parents or parents in-law

Disease: means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

Disclosure to information norm: The Policy shall be void and all Premium paid here on shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Domiciliary hospitalization: means medical treatment actually taken at home for a period exceeding 3 days, for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually undertaken while confined at home under medical advice and under any of the following compelling circumstances:

a. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital

OR

b. The patient takes treatment at home on account of non availability of a room in a hospital.

Emergency Care: means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and required immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Family Floater: means a Policy described as such in the Schedule where under the Insured and his or her Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents the Company's maximum liability for any and all claims made by the Insured and/or all of the Dependents during the Policy Period.

Grace Period: means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which

no premium is received.

Hospital/Nursing Home: means any institution established for in-patient care and day care treatment of Illness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all the minimum criteria as under:

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

Hospitalization: means admission in a Hospital/Nursing Home for minimum period of 24 consecutive hours in Inpatient Care except for specified procedures / treatments, where such admission could be for period of less than 24 consecutive hours.

Hospitalisation Expenses means expenses for treatment in any Instance of Illness or accidental injury as In Patient in a Hospital/Nursing Home for a minimum period of 24 hours (except in respect of Day Care Treatment), as admissible under the Policy.

Intensive Care Unit: Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Instance of Illness means treatment for a continuous period and includes relapse within 45 days from the date of last consultation at the Hospital/Nursing Home where treatment was taken. Occurrence of same illness after a lapse of 45 days will be considered as fresh illness for the purpose of this Policy.

Illness: means sickness or disease or a pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy period and requires medical treatment.

Acute condition: is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

Chronic condition: A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it comes back or is likely to come back.

Injury: means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

In-patient: means the person(s) named in the Schedule to this Policy who is/are admitted to Hospital/Nursing Home and stays for at least 24 hours for the sole purpose of receiving medical treatment covered under the Policy.

Inpatient Care: means a treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Insured/Insured Person: means the person(s) named in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

Maternity expenses: shall include - (a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization). (b) expenses towards lawful medical termination of pregnancy during the policy period.

Medical Charges: mean reasonable charges unavoidably incurred by the Insured/Insured Person for the medical treatment of disease, illness or injury, the subject matter of the claim as an In-patient in a Hospital/ Nursing Home, and includes the costs as defined under Hospitalisation and Pre & Post Hospitalisation Expenses.

Medical Practitioner: is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license, provided that this person is not the Insured/Insured Person or a member of his/her family.

Medical Expenses: means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Medical Advise: Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

Medically Necessary: treatment means any treatment, tests, medication, or stay in a Hospital/Nursing Home which

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

New Born Baby: means those babies born to the Insured/Insured Person and his/her lawfully wedded spouse during the Policy Period aged between 1 day and 90 days both days inclusive.

Network provider: means hospitals or health care providers enlisted by an insurer or a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

Non-Network: means any hospital, day care centre or other provider that is not part of the list of Network.

Notification of a Claim: is the process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address/telephone number to which it should be notified.

OPD Treatment (Outpatient): OPD treatment is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for a diagnosis and treatment based on the advice of a medical practitioner. The Insured is not admitted as a Day Care or Inpatient.

Policy: means this Policy document, the Proposal Form, including endorsements and the Schedule.

Policy Period: means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.

Policy Year: means a year from the date of inception.

Proposal Form: means the proposal and any other information given by the Insured to the company prior to the inception of the Policy which forms the basis of this contract of insurance.

Post-hospitalisation expenses: means relevant medical expenses incurred during a period upto 60 days after hospitalisation for treatment of disease, illness or injury sustained and considered as part of a claim for Hospitalisation admissible under this Policy.

Pre-existing disease: means any disease/illness/injury or related condition for which Insured Person(s) had signs or symptoms, and / or diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first Policy taken from Us.

Pre Hospitalization Medical Expenses: means medical expenses incurred immediately before the Insured Person is hospitalized provided that;

I. such Medical Expenses are incurred for the same condition for which the Insured Persons's hospitalization was required and

ii. The Inpatient Hospitalization claim for such hospitalization is admissible by Us

Post Hospitalization Medical Expenses: means medical expenses incurred immediately after the Insured Person is discharged provided that;

i. such medical expenses are incurred for the same condition for which the Insured Person's hospitalization was required and

ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by Us

Portability: Portability means transfer by an individual health insurance policy holder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another or from one plan to another plan o f the same insurer, provided the previous policy has been maintained without any break.

Qualified Nurse: means a qualified person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Reasonable and Customary Charges: means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services among comparable providers only, taking into account the nature of the illness / injury involved .

Renewal: Renewal defines the terms on which the contract of Insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of all waiting periods and Cumulative Bonus (if applicable).

Room Rent: means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

Schedule: means Schedule attached to and forming part of this Policy mentioning the details of the Insured/Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Subrogation: Subrogation shall mean the right of the Insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

Sum Insured means, subject to terms, conditions and exclusions of this Policy, the Sum Insured representing the Company's maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of the Insured/ Insured Person.

In case of two year policies, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits upto the full Sum Insured as opted will be available for the second year.

In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

In respect of an admissible claim for treatment of a Critical Illness listed under this Policy, reimbursement upto twice the available Sum Insured shall be payable, wherever opted.

Surgery or Surgical procedure: means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital/Nursing Home or Day Care centre by a Medical Practitioner.

Third Party Administrator or TPA/Service Provider means an organisation or institution that is licensed by the IRDAI to act as a TPA by the Company to provide Policy and claims facilitation services to the Insured/Insured Person and the Company.

Alternative Treatment: Alternative treatments are forms of treatments other than treatment under "Allopathy" or "Modern Medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Unproven/Experimental treatment: Treatment including drug experimental therapy which is not based on established medical practice in India and is a treatment experimental or unproven.

C. SCOPE OF COVERS

The Company hereby agrees to pay in respect of an admissible claim, any or all of the following Medical Expenses subject to the Sum Insured, limits, terms, conditions and exclusions contained or otherwise expressed in this Policy.

I. Basic Cover

1. Hospitalisation Expenses: If any Insured Person suffers an Illness or Accident during the Policy Period requiring Hospitalization as an inpatient, then Company will pay:

i. Fees of Surgeon, Anesthetist, Nurses and Specialists;

ii. Cost of Operation Theatre, diagnostic tests, medicines, blood, oxygen and internal appliances like pacemaker as long as these are medically necessary;

iii. Room Rent/ Boarding & Nursing as per actuals limited to 1% of Sum Insured (excluding cumulative bonus) per day subject to a maximum of Rs.4,000/- per day;

iv. ICU Rent/Boarding & Nursing as per actuals limited to 2% of Sum Insured (excluding cumulative bonus) per day subject to a maximum of Rs.6,000/- per day;

v. Provided that, expenses on account of Room Rent/ ICU Boarding & Nursing if incurred higher than the limits mentioned at iii & iv above, shall be reduced in the same proportion as such actual costs bears to the eligible limits above. Such limits shall not apply where Optional Cover for Waiver of Room Rent Sub-limits has been opted.

2. Pre-Hospitalisation Expenses

Company will pay the Medical Expenses incurred in the 30 days immediately before Insured is Hospitalized, provided that:

i. Such Medical Expenses were in fact incurred for the same condition requiring subsequent Hospitalization, and;

ii. We have accepted the claim under Section I 1. "Hospitalization expenses."

3. Post-Hospitalisation Expenses

Company will pay the Medical Expenses incurred in the 60 days immediately after Insured is discharged, provided that:

i. Such Medical Expenses were in fact incurred for the same condition for which Insured's Hospitalization was required, and;

ii. We have accepted the Claim under section 1. "Hospitalization expenses"

4. Day Care Expenses

Company will pay the Medical Expenses incurred for a Day Care Treatment where the treatment or surgery is taken by Insured as an inpatient and;

- Which is undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a hospitalization of more than 24 hours.

5. Domiciliary Hospitalisation Expenses

Company will pay Medical Expenses incurred for Domiciliary Hospitalization provided that treatment is actually taken at home for a period exceeding 3 days, for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually undertaken while confined at home under medical advice and under any of the following compelling circumstances:

i. The condition of the Insured Person is such that he/she is not in a condition to be removed to a Hospital

OR

ii. The Insured takes treatment at home on account of non availability of a room in a hospital.

If We accept a claim under this Section, We will not make any payment for Post-Hospitalization expenses. Pre-hospitalization expenses for up to 30 days will be payable.

6. Hospitalisation due to Accident

In the event of the Sum Insured having been exhausted for any reason and the

Insured/Insured Person have to subsequently, during a Policy Year, incur any expenses on hospitalisation solely attributable to any Accident, then the Sum Insured shall be reinstated to the extent of the eligible claim amount arising out of such hospitalisation. However such reinstatement shall not exceed the original Sum Insured.

Reinstatement shall be available only once during a Policy Year and maximum amount payable under a single claim shall not exceed the Sum Insured opted under the Policy in case of a floater and individual Sum Insured in case of individual cover.

7. Maternity Cover

Medical expenses for the delivery of a child (including pre-post natal expenses) and/or expenses related to a medically necessary and lawful termination of pregnancy shall be covered during the Policy limited to maximum 2 deliveries and/or termination(s) or either during the lifetime of an Insured/Insured Person subject to a maximum of 10% of opted Sum Insured or Rs. 20,000 for normal delivery and 20% of Sum Insured or Rs. 40,000 for caesarean section, whichever is lower.

a. Maximum liability of the Company per delivery or termination will be subject to limits mentioned in the Schedule to this Policy.

b. Coverage is limited to the female member who has been covered under any Policy issued by the Company for a continuous period of 48 months.

c. Pre or Post natal Medical Expenses will be covered within the limit of Sum Insured under this benefit. However any pre-post hospitalisation covered under Scope of Basic Cover, sub clause 2 & 3 above will not be covered under this.

d. Any complication arising out of or as a consequence of maternity/child birth will be covered within the limit of Sum Insured available under this benefit.

e. Coverage shall be restricted to first two children only.
The following expenses are not covered under Maternity Cover:

  a. Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.

  b. Medical Expenses for ectopic pregnancy which will be covered only under Hospitalisation Expenses under Scope of Basic Cover, sub clause I of this Section .

8. New Born Baby Cover

Coverage for a New Born Baby shall be allowed subject to a valid claim being accepted under Maternity Cover 7 above.

The following will be covered within limits of the Sum Insured available under the Maternity Cover:

a. Medical Expenses towards treatment of the Insured /Insured Person's new born baby while the Insured Person is hospitalised as an in-patient for delivery.

b. Charges incurred on the new born baby during and post birth including any complications shall be covered upto a period of 90 days from the date of birth and within the limits of Sum Insured under Maternity Cover without payment of any additional premium.

c. Reasonable and Customary vaccination expenses of the new born baby till he/she completes 90 days. Where a Policy ends before the new born baby has completed 90 days, then, such vaccinations shall be covered until the expiry of the policy only.

Coverage of the baby beyond 90 days shall be subject to addition of the baby into the policy by way of an endorsement or at the next renewal, whichever is earlier, on payment of requisite premium.

9. Ayurvedic Treatment

The Insured/Insured Person is entitled for cost of (non cosmetic) Ayurvedic treatment, subject to the maximum limit of Rs.25,000/- per Policy Year and with prior approval from the Company and with mandatory 24 hour Hospitalisation / residential inpatient with government registered hospital. This Cover is applicable only in case of diseases as listed in Annexure A

II. Optional Covers on Payment of Additional Premium

1. Double Sum Insured for Critical Illness

At the option of the Insured and having paid additional premium as determined by Company, the Policy provides for an additional amount equivalent to the Sum Insured, excluding cumulative bonus if any under Clause 19, opted under Hospitalisation towards treatment of Critical Illnesses and, whose signs or symptoms first commence more than 30 days after the commencement of the first Policy with the Company, subject to the following:

i) If these diseases are found to be pre-existing at the time of taking the Policy or opting the coverage, then the relevant waiting period as defined under pre-existing disease shall apply. Where the diagnosed Critical Illness is due to a condition listed under the section titled Exclusions in this Policy, relevant waiting period shall apply.

ii) The additional Sum Insured is exclusive and specific for the treatment of the first occurrence of the above Critical Illness undertaken in a Hospital/Nursing Home as an in-patient and will not be available for other illnesses/hospitalisation.

iii) Insured/ Insured Person(s) diagnosed with a particular Critical Illness during any of the Policy Year (s) shall not be entitled to Claim under this section for the same Critical Illness in any subsequent Policy Year. However he/she will continue to be covered under this section for the other Critical Illnesses.

iv) Additional Coverage offered under this Section is in addition to the Hospitalisation cover and the cumulative Sum Insured under both Sections could be used for covered Critical Illnesses in the event of hospitalization.

v) This cover can be opted by only those opting for Sum Insured ▪ 200,000/- and above.

2. Waiver of Room Rent Sub limits

At the option of the Insured and having paid additional premium as determined by Company, the limits specified with respect to
Room Rent/ Boarding & Nursing
ICU Rent/Boarding & Nursing
under I - Basic Cover, 1 - hospitalization expenses, iii & iv Shall not be applicable and expenses under such Coverage shall be payable as per actual incurred (without applying the sublimit).

III. Value Added Covers

Benefits under this Section are Value added covers payable upto the limit of the Sum Insured as specified below against each cover and shall not exceed the overall limit of Sum Insured opted by the Insured during the Policy Year. Benefits under each value added cover shall be available separately to each Insured/Insured Person available per hospitalisation. The following are the Value added covers available for the Insured:

i) Hospital Cash

This Policy provides for payment to the Insured / Insured Person of a daily Hospital Cash allowance of Rs 500 per day from day 4 to day 10, provided hospitalisation exceeds 3 days continuously.

ii) Ambulance Charges

This Policy provides for reimbursement to the Insured/ Insured Person for expenses incurred towards his / her transportation by ambulance to the Hospital / Nursing Home for treatment of the disease / illness / injury necessitating his / her admission to Hospital / Nursing Home upto a maximum of Rs 1,500/- per hospitalisation.

iii) Recovery Benefit

This Policy provides for payment to the Insured / Insured Person of a lump sum amount of Rs 5,000/- in the event his/her hospitalisation for a disease / illness / injury for a continuous period of not less than 10 days.

iv) Health Check Up

The Policy provides for reimbursement of charges towards a Comprehensive Health Check-Up for all Insured/Insured Persons at the end of every four continuous claim free Policy Years limited to 1% of average Sum Insured excluding cumulative bonus. This limit is available per Insured / Insured Persons in case of an individual Policy and for all members put together in case of a floater.

The benefits available under this Section are subject to the following conditions:

i) A valid claim should, have been admitted under the Policy, for admission

of liability under C-I- 1, 2 and 3 above. Value added covers shall not apply to any of the claims under Clauses 5, 7, 8 and 9 under Section C titled "Scope of Covers"

ii) All Value added covers are inbuilt into the Policy and available without any additional premium.

D. EXCLUSIONS

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. All pre-existing diseases / illness / injury / conditions as defined in the Policy, until 36 months of continuous covers have elapsed since inception of the first Policy with us.

2. Any disease contracted and/or medical expenses incurred in respect of any disease/illness by the Insured/Insured Person during the first 30 days from the commencement date of the Policy except in case of accidental injuries. This exclusion doesn't apply for Insured/Insured Person having any health insurance indemnity policy in India at least for 1 year prior to taking this Policy as well as for subsequent renewals with the Company without a break.

3. All expenses along with their complications on treatment towards Cataract, Hysterectomy other than for malignancy, Uterine prolapse including any condition requiring Hysterectomy, Polycystic Ovarian Diseases, Myomectomy for Fibroids, Knee Replacement Surgery (other than caused by an Accident), Osteoarthritis and Osteoporosis if age related, Arthritis, Rheumatism, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertibral discs(other than caused by accident), Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary, uro-genital and biliary systems, Benign Prostate Hypertrophy, Hydrocele, Congenital internal anomaly, Fistula in anus, Piles, Fissures, Fibroids, Dilatation & Curettage for treatment purposes, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, gastric and duodenal ulcer, any type of Cysts / Nodules / Polyps, and any type of Breast lumps, benign ear, Nose and Throat disorders and surgeries Chronic Nephritis and Nephritic Syndrome, Hypertension and Diabetes and related complications during the first two years (24 months) of continuous operation of this insurance cover.

   Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper / Hypoglycaemic Shocks.

   Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed / Haemorrhages. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing Exclusion 1 above shall apply.

4. Domiciliary hospitalization expenses in respect of following:

   a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,

   b. Arthritis, Gout and Rheumatism,

   c. Chronic Nephritis and Nephritic Syndrome,

   d. Diarrhoea and all type of Dysenteries including Gastroenteritis,

   e. Diabetes Mellitus and Insipidus,

   f. Epilepsy,

   g. Hypertension,

   h. Psychiatric or Psychosomatic Disorders of all kinds,

   i. Pyrexia of unknown Origin.

5. Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 48 months of continuous coverage has elapsed since the inception of the first Policy with the Company. However, this exclusion / waiting period will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

6. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an Accident.

7. Genetic disorder and stem cell implantation/surgery.

8. Dental treatment or surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.

9. Birth control procedures, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception.

10. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, vaccinations except post-bite treatment for new born baby up to 90 days, issue of medical certificates and examinations as to suitability for employment or travel.

11. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III) or Lymphadinopathy Associated Virus (LAV) or Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV and sexually transmitted diseases.

12. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.

13. Instrument used in treatment of Sleep Apnoea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.

14. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

15. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD)

16. Treatment for general debility, ageing, convalescence, rundown condition or rest cure, Congenital external anomaly/ies or defects, sterility, infertility including IVF, impotency, venereal disease, puberty, menopause or intentional self-injury, suicide or attempted suicide(whether sane or insane).

17. Certification / Diagnosis / Treatment by a family member or from persons not registered as Medical Practitioners under the respective Medical Councils, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven.

18. Ailment requiring treatment due to use, abuse or a consequence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation.

19. Any illness or hospitalisation arising or resulting from the Insured/Insured person or any of his family members committing any breach of law with criminal intent.

20. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.

21. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised.

22. Any stay in Hospital/Nursing Home without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.

23. Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganization of personality or mind, or emotions or behaviour, Parkinson's or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition").

24. Any cosmetic surgery unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity/morbid obesity or treatment / surgery /complications/illness arising as a consequence thereof.

25. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital/Nursing Home.

26. Costs of donor screening and organ.

27. Costs incurred on all medical treatments other than Allopathy Treatments. Ayuvedic expenses covered to the extent of coverage provided in Annexure A.

28. Insured/ Insured Persons whilst engaging in speed contest or racing of any

kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.

29. Insured/Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air Charter Company.

30. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

31. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.

32. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured/Insured Person was hospitalized, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer / thermometer and any medical equipment that is subsequently used at home except when they form part of Room expenses.

33. Any condition after the point at which it is certified by the attending Medical Practitioner to be of such a nature that further medical treatment may serve to stabilize or maintain it but it is unlikely to result in a material improvement within a reasonable time.

34. Service charges levied by the Hospital/Nursing Home, except registration / admission charges.

35. Pre-Post hospitalization expenses of the donor, donor screening, cost of organ or any other medical treatment for the donor consequent on the harvesting.

E. CLAIMS PROCEDURE

It is a condition precedent to the Company's liability that upon the discovery or happening of any disease/illness/injury that may give rise to a claim under this Policy, the Insured/Insured Person shall:

1. Claim Notification

Give immediate notice to the TPA named in this Policy/Health Card, by calling the Help Line number as specified in the Policy/Health Card, or in writing to the address shown in the Schedule with particulars as below.

Policy Number,
Name of the Insured/Insured Person availing treatment,
Nature of disease/illness/injury,
Name and address of the attending Medical Practitioner/Hospital
Date of admission & probable date of discharge
Approximate Claim Expenses
Any other relevant information

Intimation of claim must be done at least 72 hours prior to hospitalisation in case of planned hospitalisation and within 24 hours of hospitalisation in case of an emergency hospitalisation.

2. Cashless Facility for Hospitalisation

i) The Company may provide Cashless facility for Hospitalisation expenses either directly or through the Third Party Administrator (TPA) if treatment is undergone at a Network Hospital by issue of pre-authorization by the Company or the TPA.

ii) For the purpose of considering pre-authorization and Cashless facility, the Insured/Insured Person shall submit to the TPA complete information of the disease, illness or injury requiring treatment along with necessary certification from the Medical Practitioner and/or Hospital.

iii) If claim for treatment appears admissible, Company or TPA shall issue pre-authorization to the Hospital concerned for Cashless facility whereby Hospitalisation expenses shall be paid directly by the Company directly or through the TPA as confirmed in the pre-authorization.

iv) Cashless facility for hospitalisation will not be available for treatment in Non-Network Hospital and may be declined even for treatment at Network Hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such a case, Insured/Insured Person shall bear the expenses and claim reimbursement, immediately after discharge from Hospital/Nursing Home in accordance with the stipulations herein.

v) Cashless facility for Hospitalisation benefit shall be limited exclusively to Hospitalisation Expenses incurred for treatment at a Network Hospital for disease, illness or injury which are covered under the Policy and shall not extend to any benefits under Section III titled “Value Added Cover and for Ayurvedic treatment under Section C I 9

3. Claim Processing for Reimbursement

i) The Insured/Insured Person shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 30 days of discharge from Hospital the following:-

- Claim Form Duly filled with requisite information and signed by Insured & Hospital
- Copy of the claim intimation
- Original Hospital Main Bill
- Original Hospital Bill break up (Where issued by the Hospital)
- Original Hospital Bill Payment Receipt
- Hospital Discharge Card/Summary
- Original Pharmacy Bill with supporting prescriptions
- Medical Investigation report: ECG/X-Ray / USG / CT / MRI / Histopathology / pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
- All Doctor's consultation note: confirming provisional & final diagnosis / advise for admission/medical complication / proposed line of treatment/past medical history
- Original bills and receipts for claiming Ambulance charges(if any)
- By signing the claim form you are authorizing us to collect the following documents from the Hospital. If you have obtained these documents, then please submit the same
- Operation Theatre Notes in surgical cases
- Bar code sticker & Invoice for implants and prosthesis (if used)
- In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident
- Indoor case papers

Pre and Post hospitalization Claims documents

- Duly filled claim form(s)(If claimed Separately)
- Pharmacy Bills with supporting prescriptions
- Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- All Doctor's consultation note with original bills and receipts for claiming Doctors fees,

Domiciliary hospitalization Claims documents

- Duly filled claim form(s)
- Original bills from chemists supported by proper prescription
- Original Investigation test reports and payment receipts
- Original bills and receipts for claiming Doctors fees,
- Certificate from treating doctor stating the reason for domiciliary treatment

Documents applicable if claiming under Double Sum Insured for Critical Illness

Critical Illness	Documents / Reports Needed
Cancer (of specific severity)	1. Histopathology 2. CT Scan / MRI
Coronary artery bypass grafting	1. 2D Echo studies 2. Coronary Angiography report or CT coronary angiogram 3. Trop - T, Trop - I and CPK - MB (In case of recent Acute Coronary syndrome)
First Heart Attack (of specific severity)	1. Clinical History and serial ECGs 2. Trop T, Trop I and CPK – MB 3. Coronary Angiography report 4. 2D Echo
Kidney Failure (requiring regular dialysis)	1. Renal Profile 2. Renal Biopsy (if available) 3. Neutrophil gelatinase-associated lipocalin 4. Renal CT Scan / MRI 5. Radio - isotope Renography (DMSA or MAG - 3 scan)
Multiple Sclerosis	1. Certificate from Neurologist for symptoms & signs of multiple sclerosis. 2. Evoked potential test for afferent or efferent CNS pathways. 3. CSF Report: 4 MRI
Major Organ Transplant	Basic claim documents with certification from the surgeon for the need of Organ
Stroke (resulting in permanent symptoms)	1. CT Scan or MRI 2. Certification from neurologist for permanent neurological deficit with duration
Aorta Graft Surgery	1. CT Scan 2. MRI 3. 2D Echo / Trans esophageal echocardiogram 4. Abdominal Ultrasound (for associated abdominal aneurysms) 5. Coronary Angiography 6. MRI Angiography
Primary Pulmonary Arterial Hypertension	1. Electrocardiogram or X-Ray and 2. Echocardiography 3. Pulmonary Function test 4. High Resolution Computerized Tomography Scan (HRCT-Chest) 5. Cardiac Catheterization or Pulmonary ateriography

Know Your Customer (KYC) documents viz. (address proof of claimant (nominee) and photo ID) would be required for all admissible Claims more than Rs. 100000/-.

ii) The Insured/Insured Person shall submit to the TPA at his/her own expense, documents pertaining to the post hospitalization claim within 15 days from the date of expiry of post hospitalsation coverage period.

iii) The Insured/Insured Person shall at any time as may be required authorize and permit the TPA and/or the Company or anyone deputed by them in this behalf to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.

iv) If required by the Company or the TPA, the Insured/Insured Person shall submit to medical examination by any Medical Practitioner designated by the Company or the TPA.

The Company may, at its sole discretion, call for additional information and/or carry out verification/investigation on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the assessment of loss. Verification carried out, if any, will be done by individuals or entities authorized by the Company to carry out such verification / investigation(s) and the costs for such verification/investigation shall be borne by the Company.

For determining the amount of admissible claim, applicable taxes prevailing at the time of the claim will be considered as part of claim amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Sum Insured.

4. TPA to Pay or Reject

The TPA where appointed, shall process and communicate rejection, if a claim is found to be not admissible under this Policy as authorized by the Company. However all decisions shall be the responsibility of the Company.

5. Representation against Rejection

Where rejection is communicated, the Insured/Insured Person, may if so desired, represent to the Company within 15 days for reconsideration of the decision.

6. Condition Precedent

Completed claim forms and documents must be furnished to the Company within the stipulated timelines. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if the Insured can satisfy the Company that it was not reasonably possible for the Insured to submit/give proof within such time.

The due intimation, submission of documents and compliance with requirements by Insured/Insured Person as mentioned above shall be essential failing which Company/TPA shall not be bound to entertain a claim.

7. Claims Service Assurance

1) If the Insured/Insured Person notifies a cashless facility request by sending the pre-authorization form duly filled in and signed through email, fax to the Company or its representative then within 6 hours of the actual receipt of such a request the Company will respond with:

a) Approval, or

b) Rejection

If such request has been notified during office hours (9am to 9 pm) on Monday to Saturday and the Company fails to either approve or reject or seek further information after the expiry of 6 hours from the actual receipt of the request then the Company shall be liable to pay the Insured for the delay in the following manner:

i) For delay beyond 6 hours: Rs.1,000/-

ii) The maximum amount that the Company shall be liable to pay the Insured for any delay, in respect of a single hospitalisation, shall at no time exceed Rs.1,000/-.

If such request has been notified after office hours on a working day or at any time during a holiday and the Company fails to either approve or reject after the expiry of 8 hours from the actual receipt of the request, then the Company shall be liable to pay the Insured for the delay in the following manner:

iii) For delay beyond 8 hours: Rs.1,000/-

iv) The maximum amount that the Company shall be liable to pay the Insured for any delay, in respect of a single hospitalisation, shall at no time exceed Rs.1,000/-.

2) In case of reimbursement claim, the Company shall communicate its decision on payment within 6 working days after the Insured/Insured Person submits the complete details, information and document requirements in respect of the claim. If the Insured/Insured Person has provided such information and documents as the Company requires and the Company fails to communicate its decision, then the Company shall pay Rs. 1,000/- for a delay beyond 6 days to the Insured. The maximum amounts that the Company shall be liable to pay the Insured for any delay, in respect of a single hospitalisation, shall at no time exceed Rs.1,000/-.

3) The Company will not be liable to make any payments under Clause 1 and 2 above in case of any natural event or manmade disturbance which impedes the Company's ability to make a decision or to communicate such decision to the Insured/Insured Person.

4) Any amounts paid under this Clause will not affect the sum insured as specified in the Schedule. That the Company's liability to make payments under this Clause shall at all times be restricted to the amounts specified in Clause 1 and 2 above including the maximum amount specified therein and the Insured shall not be entitled to any sum whatsoever, in excess of those amounts. That any payment made under this Clause by the Company will not amount to any admission of liability for a claim notified by the Insured. Service Assurance is applicable only to the first response on a single claim and no subsequent correspondence.

The above compensation shall be paid to the Insured/Insured Person notwithstanding the Company's obligation to pay interest in cases of delay in settlement of claims, as per Reg. 9(6) of IRDAI (PPH) Regulations.

8. Claim Settlement

Wherever a claim has not been settled within the stipulations of the Claims Service Clause above, the Company after payment of agreed compensation shall within a period of maximum 30 days on receipt of final completed set of documents/investigation reports (if applicable) offer settlement of the claim. In the event that the Company decides to reject a claim made under this Policy, the Company shall do so within a period of 30 days of receipt of the final completed set of documents/investigation reports (if applicable), in accordance with the provisions of Protection of Policyholders' Interests Regulations, 2002.

F. General Conditions

1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements or misrepresentation, mis-description or non-disclosure or suppression of any material particulars or if any material information had been withheld in the Proposal Form, personal statement, declaration or other documents, or if a claim is found to be fraudulent or any fraudulent means or device is used by the Insured/ Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

Material information to be disclosed includes every matter that the Insured/Insured Person knows, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company's decision to accept the risk of insurance and if so on those terms. The Insured must exercise the same duty to disclose those matters to the Company before the renewal, extension, variation, endorsement or reinstatement of the contract.

2. Observance of Terms and Conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy insofar as they relate to anything to be done or complied with by the Insured / Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy.

3. Reasonable Care

The Insured/Insured Person shall take all reasonable steps to safeguard against any Accident or illnesses that may give rise to any claim under this Policy.

4. Notice of Charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured/Insured Person or his/her nominees or his/her legal representative or to the Hospital/Nursing Home, as the case may be, of any benefit under the Policy shall in all cases be a full, valid and an effectual discharge by the Company.

5. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument in writing and signed by the Company shall be deemed to be part of this Policy and shall have effect accordingly.

6. Electronic Transactions

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of this Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured/Insured Person.

7. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured/Insured Person's rights or recovery thereof against any person or organization, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured/Insured Person's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. This clause does not apply to benefit sections.

8. Contribution

If there shall be existing any other insurance covering the same Insured/Insured Person whether effected by the Insured/Insured Person or not and If the Claim amount exceeds the Sum Insured under the Policy after considering the deductible or Co-pay, the Company shall not be liable to pay or contribute more than its ratable proportion of Claim. This clause does not apply where Claim amount is not exceeding the Sum Insured and/or to benefit sections under this Policy. Insured Person has the right to choose the Insurer by who Claim to be settled.

10. Co-payment

All Insured Persons above the age of 80 years (age last birthday) shall bear a co-pay of 10% for each and every claim.

11. Fraudulent Claims

If any claim 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/Insured Person or anyone acting on his / her behalf to obtain any benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons, all sums paid under this Policy shall be repaid to the Company by all Insured Persons who shall be jointly liable for such repayment.

12. Cancellation/Termination

The Company reserves the right and may at any time, cancel this Policy, on grounds of misrepresentation, fraud, non disclosure or suppression of material fact as sought to be declared on the proposal form or non co-operation of the Insured, by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured/Insured Person at his/their last known address in which case the Company shall not be liable to repay the premium for the unexpired term.

The Insured/Insured Person may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales as

Period on Risk	Rate of Premium Refunded
Up to 1 month	75% of annual Premium
Up to 3 months	50% of annual Premium
Up to 6 months	25% of annual Premium
Exceeding six months upto 365 days	Nil

An individual policy with a single Insured shall automatically terminate in case of death of the Policyholder. In case of an individual Policy with multiple Insured

Person and incase of a floater, the Policy shall continue to be in force for the remaining members of the family upto the expiry of current Policy Period. The Policy may be renewed on an application by another adult Insured Person under the Policy, whenever such is due.

In case of 2 years Policy the Company shall from the date of receipt of notice cancel the Policy and retain 15% of the pro-rata premium relating to the balance period.

Eg. 2 Year Policy issued for 730 days

Cancellation request received on day 395(1 year and 1 month)

The amount refunded will be calculated as follows:

The amount to be refunded will be 15% less than the pro-rata premium for the balance period. 2 year premium Rs 1000. Utilised period 395 days, unutilised period 335. Pro-rata premium for unutilised premium will be Rs 458.9
Refund amount shall be 458.9-15% i.e (458.9 – 68.83) = Rs 390

However, in case of a valid claim having been paid or reported under this Policy, there would be no refund of premium.

Minimum premium of Rs. 250 per policy will be retained by the Company towards administrative charges.

13. Free-look Cancellation

A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. The Insured has the option of cancelling the Policy stating the reasons for cancellation, if he has any objections to any of the terms and conditions. The Company shall refund the premium paid after adjusting the amounts spent on stamp duty charges and proportionate risk premium. Cancellation will be allowed only if there are no claims paid or reported under the Policy. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not available at the time of renewal of the Policy. Minimum premium shall not apply for free look cancellations.

14. Place/Currency

No claim shall be payable under this Policy for any treatment or expenses outside India. All claims shall be payable in India and in Indian Rupees only.

15. Income Tax benefit

Premium paid under the Policy shall be eligible for benefits under the Income Tax laws prevailing from time to time.

16. Law Applicable

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim thereunder.

17. If a claim is rejected or partially settled and is the not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and liability of the Company extinguished and shall not be recoverable thereafter.

18. Policy Period option

Policy can be issued or renewed for one year or two continuous years at the option of the Insured/ Insured Person.

19. Renewal

i. The Company shall not be bound to give notice that renewal is due.

ii. If the Insured desires renewal he/she shall apply to the Company for the same prior to expiry of the Policy Period of Insurance.

iii. 5% increase in Sum Insured will be allowed at the time of renewal, where the Policy is claim free in the expiring Policy Year. This cumulative bonus can be accumulated up to a maximum of 50% and will be reduced by 20% in the event of a claim being reported under the policy, however the basic Sum Insured will be maintained at all times.

iv. Where the Policy is issued as a Family Floater, cumulative bonus will be considered with respect to the Sum Insured of such Family Floater.

v. Renewals are deemed to be continuous when received within a period of 30 days from the date of expiry of last policy, subject however, to the effective policy inception date being reckoned from such period when the renewal premium is received by the Company.

vi. Policy would be considered as a fresh policy if there would be break of thirty or more days between the previous policy expiry date and current policy start date.

vii. The Company shall not be liable for any claim arising out of an ailment suffered or hospitalisation commencing during the period between the expiry of previous policy and date of commencement of subsequent Policy. Any disease/ condition contracted in the break in period will not be covered and will be treated as Pre-existing condition.

viii. Any enhanced Sum Insured during subsequent policy renewals will not be available for an illness, diseases, injury already contracted under the preceding policy periods. All Waiting periods as defined in the Policy shall apply for this enhanced limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

ix. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company.

x. In case of floater Policies, where dependent child crosses age 23 years, renewal can be done in a separate Policy under the same Product or any other available Products with continuity benefits.

xi. Policy shall be ordinarily renewable for lifetime unless:

a. any fraud, non cooperation, misrepresentation or suppression of material facts as sought to be declared on the Proposal form by the Insured or on his behalf is found either in obtaining insurance or subsequently in relation thereto or,

b. the Company has discontinued issue of the particular type of Policy, in which event the Insured shall have the option of renewal under any similar Policy being issued by the Company; provided however, benefits payable shall be subject to the terms contained in such other Policy. Such modification or revision of the terms and conditions of the Product shall be intimated to you 3 months in advance along with reasons of modification and revision

xii. Based on the experience of the Product, Premium, terms and conditions may be revised subject to prior approval of Insurance Regulatory and Development Authority. Such revision shall be intimated to you 3 months in advance with an option of renewal under any similar Policy being issued by Us. However, benefits payable shall be subject to the terms contained in such other Policy. Individual Claims experience loading is not applicable under the Policy.

20. Continuity Benefits

For Roll Over Cases (Portability Policies) Continuity benefits shall be offered to all Insured/Insured Persons in accordance to IRDA circular from time to time.

Portability benefits are not automatically applicable under the Policy unless application for portability has been specifically made and subsequently accepted by the Company.

Where the product is offered to the customers of a specific institution, with which the Company has a tie up, continuity of benefits will be provided under the same or similar policies available with the Insurer during such period in the event that such tie-up has been discontinued.

21. Pre-acceptance Medical Test Requirement

a. All Individuals upto 50 years (age last birthday as at Policy inception date) - The Company will rely on the declarations made on the Proposal Form. In case the declaration reveals any medical adversity, the Company may require the individual to undergo appropriate medical tests.

b. For age group 51-65 years (age last birthday as at Policy inception date) - The Individuals would be required to undergo pre-acceptance medical tests as follows-

Medical Examination Report, Treadmill Test, Lipid Profile, HbA1C, Serum Creatinine, Complete Blood Count, Urinalysis.

c. For the following category:

my:health Medisure Classic Insurance

Scenarios	Medical Tests Requirement
Age group 66 yrs and above	Medical Examination Report, Treadmill Test, Complete Blood Count, Lipid Profile, HBA1C, Serum Creatinine, Urinalysis, SGOT, SGPT and GGT
Age group 51 - 65 years with Optional Cover for Double Sum Insured for Critical Illness	
Optional Cover for Double Sum Insured for Critical Illness at Renewal with or without Claim irrespective of age	

(age last birthday as at Policy inception date) to be considered

The Company reserves its right to require any individual to undergo such medical tests or where required any further additional tests, at the sole discretion of the Company to determine the acceptance of a Proposal.

In case of accepted proposals, the Company shall reimburse 50% of the pre-acceptance medical test costs. (on our pre agreed rates with the network provider)

22. Medical Underwriting

Proposers above 50 years of age and those having medical history are subject to Medical Underwriting by the Company. We reserve the right to accept such proposals on standard terms/Decline/Accept with exclusion or Premium loading (up to maximum of 100% on basic Premium). These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us.

23. Endorsements

Following type of endorsement are permissible under the Policy.

Premium Bearing

- Increase in Sum Insured - Subject to medical underwriting permissible at Renewal
- Decrease in Sum Insured - Permissible at Renewal unless wrongly entered
- Addition of member - Newly married spouse or New born baby permissible at Renewal
- Policy cancellation
- Addition of Covers - Subject to medical underwriting permissible at Renewal unless missed out while booking the Policy.

Non Premium Bearing

- Address change
- Corrections - Names, address etc
- Change of Occupation

Above list is indicative.

24. Customer Support

You can Contact us on

HDFC ERGO General Insurance Co. Ltd.
Stellar IT Park, Tower-1
5th Floor, C - 25, Sector - 62
Noida - 201 301

Toll Free:1800 2 700 700 (Accessible from India only)
Phone (UAN): 1860 2000 700 (Local charges applicable)
Fax (UAN): 1860 2000 600 (Local charges applicable)
Email: healthclaims@hdfcergo.com

25. Grievances Redressal Procedure

Our Grievance Management process follows a philosophy of providing ease of complaint redressal to the customer as well as influencing effectiveness of service delivery by in depth analysis of grievance causes.

You or your legal representative can approach us through the below mentioned touch points:

- Call us on toll-free number: 1800 209 5846
- Email on 'help@ltinsurance.com'
- Write to us at: Head-Customer Services at our Corporate Office Address

In case You are not satisfied with the decision of the above office, You may:

- Email on 'grievance@ltinsurance.com'
- Write to us at: Grievance Officer at our Corporate Office Address

HDFC ERGO General Insurance Company Limited shall abide by Insurance Regulatory and Development Authority (Protection of Policy holders Interests) Regulations, 2002. Under this Regulation and with an objective to provide a forum to Policy holders for resolution of claims related complaints, Insurance Ombudsman has been constituted under the aegis of Governing Body of Insurance Council, list of which is given below. For further Information you could refer to http://www.gbic.co.in/contact.html.

Names of Ombudsman and Addresses of Ombudsmen Centres
2nd Floor, Ambica House, Near C U Shah College, 5, Navyug Colony, Ashram Road, **AHMEDABAD** - 380 014 Tel.: 27546150 Fax: 079-27546142 Email: insombalhd@rdiffmail.com
62, Forest Park, **BHUBANESHWAR** - 751 009. Tel.: 2535220 Fax: 0674 - 2531607 Email:susantamishra@yahoo.com / ioobbsr@vsnl.net
S.C.O No.101,102 & 103, 2nd Floor, Batra Building, Sector 17 D, **CHANDIGARH** - 160 017 Tel.: 0172 - 2706196 | EPBX:0172 - 2706468 Fax: 0172 - 2708274
Fatima Akhtar Court , 4th Floor, 453 (Old 312) Anna Salai, Teynampet, **CHENNAI** - 600 018 Tel.: 24333678/24333668/24335284 Fax: 044 - 24333664 Email:insombud@md4.vsnl.net.in
2/2 A, Universal Insurance Bldg, Asaf Ali Road, **NEW DELHI** - 110 002 Tel.: 23239611 Fax: 011 - 23230858 Email: insombudsmandel@netcracker.com
6-2-46, Yeturu Towers, Lane Opp. Saleem Function Palace, A C Guards, Lakdi-Ka-Pool, **HYDERABAD** - 500 004 Tel.: 55574325 Fax: 040 - 23376599 Email:insombud@hd2.vsnl.net.in
2nd Floor, CC 27/2603 Pulinat Bldg, Opp. Cochin Shipyard, M G Road, **ERNAKULAM** - 682 015 Tel.: 2373334/2350959 Fax: 0484 - 2373336 Email:insuranceombudsmankochi@hclinfinet.com
North British Building 29, N S Road, 3rd Floor, **KOLKATTA** - 700 001 Tel.: 22212666/22212669 Fax:033-22212668
Jeevan Bhavan, Phase 2, 6th floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW** - 226 001 Tel.: 0522-2201188/2231330/2231331 Fax: 0522 - 2231310 E-mail: ioblko@sancharnet.in
3rd Floor,Jeevan Seva Annexe (above MTNL), S V Road, Santacruz (W), **MUMBAI** - 400 054 Tel: 26106889 | EPBX:022-26106889 Fax: 022 - 26106052/26106980 Email:ombudsman.i@hclinfinet.com
Aquarius Bhaskar Nagar, R G Baruah Road, **GUWAHATI** - 781 021 Tel: 2413525 | EPBX:0361 - 2415430 Fax: 0361 - 2414051

1st Floor, 117, Zone II (Above D M Motors Pvt. Ltd.), Maharana Pratap Nagar, **BHOPAL**- 462 011 Tel: 0755 - 2769200 | Fax: 0755-2578103 Email:insombmp@satyam.net.in
2nd Floor, CC 27/2603 Pulinat Bldg, Opp. Cochin Shipyard, M G Road, **ERNAKULAM** - 682 015 Tel: 2373334/2350959 | Fax: 0484-2373336 Email:insuranceombudsmankochi@hclinfinet.com
Secretary General Governing Body of Insurance Council 5th Floor, Royal Insurance Building, 14 Jamshedji Tata Road, Churchgate, Mumbai - 400 020 Tel.: 022 - 22817515 Email: inscoun@vsnl.net

23. IRDAI REGULATIONS:

This Policy is subject to Regulations of IRDAI (Protection of Policyholder's Interests) Regulations, 2002 as amended from time to time.

ANNEXURE A

List of Ayurvedic Treatments covered

Coverage for Ayurvedic treatments is applicable only if taken for any of the below given illnesses. This coverage is subject to terms, conditions, definitions, waiting periods and exclusions under the Policy.

Vascular Disorders & Cardiac Conditions	Neuralgia
Multiple Sclerosis	Osteoarthritis
Body Paralysis and Hemiplegia	Rheumatoid arthritis
Diabetes	Cervical & Lumbar spondylosis
Blood Pressure	Psoriasis
High Cholesterol	Eczema
Slip Disc & Low Back Pain	Sciatica
Cancer	Migraine
E.N.T. Diseases	Acid peptic disorders
Epilepsy	Piles
Gastric and liver problems	Fistula
Eye disorders	Asthma
Kidney and bladder stones	Bronchitis
Polio	Sinusitis