HDFC ERGO General Insurance Company Limited

Policy Wording

NEW HEALTHWISE

Eligibility

a. This policy covers persons in the age group from 18 years to 70 years.
b. The policy offers option on covering on individual sum insured basis and on family floater basis.
c. This policy can be issued to an individual and/or family
d. The family includes spouse, dependent children and dependent parents.

Policy Period

- The policy will be issued for 1 year period

Sum Insured

Minimum & maximum Sum Insured per insured personal shall be Rs. 50000 and Rs. 1000000 respectively

Salient Features & Benefits

SECTION I – HOSPITALISATION BENEFITS

a) Room, Boarding Expenses as provided by HOSPITAL/NURSING HOME subject to a limit of 1% of the Sum Insured per day or Rs 5,000 per day, whichever is less and for Intensive Care Unit 2% of the Sum Insured per day or Rs 10,000 per day, whichever is less;

b) Nursing Expenses;

c) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees subject to a limit of 40% of Sum Insured per claim;
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d) Anaesthesia, Blood, Oxygen, Operation theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker, Artificial Limbs and similar expenses.

e) Hospital Cash Allowance, a lump sum amount of 1% of the sum insured per claim, in case of continuous hospitalization for a period of 15 days, within the overall
Sum Insured of the INSURED PERSON.

f) Ambulance charges in an emergency, subject to limit of 1% of Sum Insured per hospitalization or Rs 2000/- per claim, whichever is less, within the overall Sum Insured of the INSURED PERSON.

g) Reimbursement of expenses, subject to a maximum of Rs 750/- per insured person, towards Health Check up for the insured person, after 4 consecutive claims free years.

h) Hospitalization expenses of person donating an organ during the course of organ transplant will also be payable subject to the above sub limits applicable to the Insured Person within the overall Sum Insured of the Insured Person.

The above benefits are available only for Allopathic mode of treatments. The limit for an alternative mode of recognized treatment being Homoeopathy, Ayurvedic and similar such recognized treatments requiring hospitalisation, shall be restricted to 20% of ANY ONE YEAR LIMIT subject to a maximum of Rs. 25,000/- (Rupees Twenty Five Thousand Only).

The claim amount payable towards the treatment of following disease, illness, medical condition or injury is subject to a limit of:

Treatment	Limit per Claim
Cataract	7.5% of SI subject to max. Rs. 20,000
Piles, Fistula, Fissure, Tonsillitis, Sinusitis	10% of SI subject to max. Rs. 30,000
Benign Prostate Hypertrophy, Hernia	20% of the SI subject to max. Rs. 50,000
Knee/Hip Joint Replacement, All Types of Cancer, Renal Failure	50% of SI subject to max. Rs. 1.5 lakhs
Appendicitis, Gall Bladder, Stones & Gynaec. Disorders	25% of SI subject to max. Rs. 40,000
Dialysis, Chemotherapy and Radiotherapy	Max. 10% of SI per month

Expenses on hospitalisation are admissible only if hospitalisation is for a minimum continuous period of twenty- four (24) hours. However, this time limit will not apply to the specific 138 minor surgeries, treatments & procedures mentioned herein below which are taken in HOSPITAL / NURSING HOME where the INSURED PERSON is discharged on the same day he / she may be admitted. Such treatment will be eligible for Hospitalisation Benefit under the policy.

The annual limit for DOMICILIARY HOSPITALISATION EXPENSE under the policy shall be restricted to 15% of the ANY ONE YEAR LIMIT stated in the policy Schedule subject to a maximum of Rs. 50,000/- (Rupees Fifty Thousand Only) and provided that the DOMICILIARY HOSPITALISATION EXPENSE cover shall be available only in respect of treatments taken under the Allopathic mode of treatment and shall be further subject to the above conditions and exclusions.

Annual Sum Insured
The Annual Sum Insured would Range from: `100,000 to `50, 00,000 across three plan variants- Silver, gold and Platinum.

Renewal Incentives We will offer cumulative bonus of 5% for every claim free year accumulating up to 50% under both Individual and floater Sum Insured option. In the event of a claim the bonus shall be reduced by the 5%of Basic Sum Insured at the time of renewal. However this reduction will not reduce the Sum Insured below the basic Sum Insured of the policy.

Free Look Period:
You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of canceling the Policy stating the reasons for cancellation and You shall be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel your Policy only if You have not made any claims under the Policy. All Your rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and is not available at the time of renewal of the Policy.

Exclusions
The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any INSURED PERSON in connection with or in respect to:

1. (a) All DISEASEs or INJURIES which are a PREEXISTING CONDITION when the cover incepts during the first policy period.
(b) Any heart, kidney and circulatory disorders in respect of the Insured Person suffering from pre existing Hypertension and/or Diabetes.

These diseases shall however be covered after 3 years of consecutive insurance policy with the Company, which were renewed each year without any break.

2. Any DISEASE other than those stated in clause 3.3, contracted by the INSURED PERSON during the first thirty (30) days from the commencement date of this
policy period. This exclusion shall not however apply if the INSURED PERSON was covered under a Health policy issued by the Company for a continuous
preceding twelve (12) months period from the commencement date without any break and/or the

INSURED PERSON is hospitalized due to injuries suffered due to accident arising independent of the disease.

3. (a) During the first policy period of this policy, expenses for treatment of following DISEASES are excluded:
FIRST YEAR EXCLUSIONS
Treatment of Congenital Internal Diseases, ASD, VSD, Tetrology of Fallot, etc. Any type of Migraine/Vascular Headache.
Stones in the Kidney & Billary systems. Surgery on Tonsils/Adenoids,Mastoidectomy, Tympanoplasty, Gastric & Duodenal Ulcer.
Any type of Cysts/Nodules/Polyps. Any type of Breast Lumps.

(b) During the first two years of policy periods of this policy, the expenses of the following Diseases are excluded:
FIRST TWO YEAR EXCLUSIONS
Treatment of Spondylosis/Sponditititis. Intervertebra Disc Prolapse and such other degenerative disorders.
Cataract. Fistula. Piles.
All types of Hernia. Hydrocele.
Benign Prostatice Hypertrophy. TURP.
Hysterectomy for Menorrhagia or Fibromyoma or Myomectomy or Prolapse of Uterus.
Fissures in Anus. Sinusitis.
Knee/Hip Joint Replacement. Chronic Renal Failure.
Heart Disease.
Any type of Carcinoma/Sarcoma/Blood Cancer. Osteoarthritis and Osteoporosis.
Non-infective Arthritis. Undescendent Testes. Surgery of Genito Urinary. Gout & Rheumatism.
Hypertension. Diabetes.
Calculus Diseases.
Surgery of Varicose Veins and Varicose Ulcers. Dilation & Curettage.
Dialysis required for Chronic Renal Failure.

If these DISEASES (other than congenital internal DISEASE or defects) are a PRE-EXISTING CONDITION at the time of proposal, they will not be covered during subsequent period if this policy is renewed. If the INSURED PERSON is aware of the existence of congenital internal DISEASE or defects before inception of policy, the same will be treated as a PRE-EXISTING CONDITION.

4. Claims arising from, as a consequence of or involving investigations, operations or treatment of a purely cosmetic nature; or for obesity; or undertaken to facilitate pregnancy or to cure impotence or to improve potency.

5. INJURY or DISEASE directly or indirectly caused by or arising from or attributable to:

(i) War, war-like operations, act of foreign enemy, invasion of Indian territory or any part thereof, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion, military or usurped power, or loot or pillage in connection with the foregoing, seizure, capture, confiscation, arrests, restraints and detainment by order of any governments or any other authority, unless it is proved by the Insured to the satisfaction of the Company that such loss or damage or contingency or cost or expenses of whatsoever nature are not directly or indirectly caused by, resulting from or in connection with any war, war- like operations, act of foreign enemy, invasion of Indian territory or any part thereof, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion, military or usurped power, or loot or pillage in connection with the foregoing, seizure, capture, confiscation, arrests, restraints and detainment by order of any governments or any other authority. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.
(ii) Ionising radiation or contamination by radioactivity from any source whatsoever.
(iii) Nuclear weapons material.

6. Circumcision unless necessary for treatment of a DISEASE not excluded hereunder or as may be necessitated due to an ACCIDENT, vaccination or inoculation or change of life; or cosmetic or aesthetic treatment of any description including any complications arising from these treatments, whether or not for psychological reasons, plastic surgery other than as may be necessitated due to an ACCIDENT or as a part of any illness.

7. The cost of spectacles and contact lenses, hearing aids, dental treatment or surgery of any kind unless requiring hospitalisation.

8. Convalescence, general debility, run-down condition or rest cure; congenital external DISEASE , sterility, venereal DISEASE, intentional self INJURY or injury caused by any Insured Person to his relative who is also an Insured Person under this Policy, suicide or attempted suicide and use of intoxicating drugs or alcohol, Tubectomy, Vasectomy, Any fertility, sub-fertility or assisted conception operation - IVF, GIFT, ZIFT, Embryo transfer, donor ovum and related costs.

9. All expenses arising out of any condition directly or indirectly caused to or associated with Human T-cell Lymphographic Virus Type 111 (HTLB-111) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.

10. Charges incurred at HOSPITAL / NURSING HOME primarily for diagnostic, x-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any DISEASE or INJURY, for which confinement is required at a HOSPITAL/NURSING HOME or at home under DOMICILIARY HOSPITALISATION.

11. Expenses on vitamins and tonics unless forming part of treatment for INJURY or DISEASEs as certified by the attending MEDICAL PRACTITIONER.

12. Loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

13. Treatment arising from or traceable to pregnancy and childbirth (including voluntary termination of pregnancy) and childbirth, (including caesarean section). Expenses incurred in relation to infant(s) born after delivery (Baby/ies) until the Baby/ies become(s) three (3) months of age.

14. Naturopathy treatment.

15. Any routine or preventive examinations, vaccinations, inoculations or screening.

16. Any Out Patient treatment charges.

17. Sex change or treatment, which results from or is in any way related to sex change.

18. Hormone Replacement Therapy.

19. All & every kind of Lasik Surgery.

20. All kinds of treatment of psychiatric, mental or nervous conditions, insanity, etc.

21. Use of intoxicating drugs alcohol and the treatment of alcoholism, solvent abuse, drug abuse or any addiction and medical conditions resulting from or related to, such abuse or addiction.

22. Any person whist engaging in speed contest or racing of any kind(other than on foot), bungee jumping, parasailing, ballooning, parachute, skydiving, paragliding ,hang gliding, mountain or rock climbing necessitating the use of ropes or guides, pot holding, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow & ice sports and activities of similar hazards.

23. The following expenses incurred are not covered under the policy: Admission charges, service charges,

registration charges, telephone charges, television charges, electric charges, water charges, aya & attendant fees, barber charges, shaving charges, blades charges, toothpaste & brush, soaps, food items and similar items.

24. External Medical Equipment of any kind used at home as post hospitalization care including cost of instrument used in treatment of sleep appnea syndrome(C.P.A.P), continuous Peritoneal Ambulatory Dialysis(C.P.A.D) and Oxygen Concentrator for Bronchial Asthmatic condition.

Portability:

If you are insured continuously and without interruption under a plan issued by an Indian general insurer and you want to shift to us on renewal, New Healthwise policy offers you transfer of accrued benefits and make due allowances for waiting period etc,as per regulations & guidelines on portability issued by IRDA. If the insured person transfers from any other insurer and enhances coverage, then the portability benefits will be offered only in respect to the previous sum insured

Claim Procedure

1) It shall be a condition precedent to the Company's liability under this policy that on the occurrence of the event which may give rise to a claim under this policy, the INSURED PERSON or the INSURED PERSON's representative shall immediately contact and intimate the TPA who has been appointed under the policy to provide claim services. The INSURED PERSON shall immediately give written notice to the TPA at the address given in the Schedule and thereafter submit full particulars of the claim to the TPA within seven (7) days from the date of hospitalisation.

2) All supporting documents relating to the claim must be submitted to the TPA within thirty (30) days from the date of discharge from the hospital. In case of post hospitalisation treatment days, all claim documents should be submitted to the TPA within seven (7) days after completion of such treatment.

3) The INSURED PERSON shall obtain and furnish to the TPA, all original bills, receipts and other documents upon which a claim is based and such additional information and assistance as the TPA may require in dealing with the claim.

4) Treatment taken at a Network Hospital means treatment given by a provider of health care services, which has a participation agreement with the TPA or its affiliate directly or through one or more other organizations to provide claims services to INSURED PERSONS under the policy.

5) Treatment taken at a Non-Network Hospital means treatment given by a HOSPITAL / NURSING HOME which is not a Network Hospital.

6) A claimant under the policy shall abide by the rules and regulations made in this behalf by the TPA and intimated to the INSURED PERSON in the form of a 'Membership Guide' or in any other form by whatever name called. It shall be the INSURED PERSON's responsibility to ensure that all INSURED PERSONS are made aware of the said rules and regulations as amended from time to time by the TPA / Company.

7) All certificates, information & evidence required by the Company/TPA shall be furnished at no expense to the Company / TPA and shall be in such form and of such nature as the Company may prescribe. When required by the Company / TPA, the INSURED PERSON shall at its own expense submit to medical examination in respect of any claim.

8) In the event of a claim under this policy, the INSURED PERSON and the INSURED PERSON must fully co-operate with the Company/TPA in its handling of the claim including, but not limited to, the timely submission of all medical and other reports, and full co-operation with all physical examinations that the Company/TPA may require.

9) Medical advice of a MEDICAL PRACTITIONER shall be sought and followed promptly on the occurrence of any INJURY or DISEASE and the Company shall not be liable for any part of a claim which in the opinion of a physician appointed by the Company/TPA, arises from the unreasonable or wilful neglect or failure of an INSURED PERSON to seek and remain under the care of a MEDICAL PRACTITIONER.

10) It shall be the duty of INSURED PERSON to obtain pre-authorization of all hospitalization events by the TPA/Company. Pre-Authorization shall mean review by the TPA or the Company of the "need" for inpatient care or other medical care upon a reference being made by an INSURED PERSON before admission to a HOSPITAL/NURSING HOME. An INSURED PERSON shall be required to make the said reference for pre-authorization at least 48 hours prior to a planned hospitalization. However, for emergency hospitalizations, a reference for pre-authorization shall be made within 24 hours of admission to a HOSPITAL/ NURSING HOME.

11) Reimbursement of claims for hospitalizations that have not been pre-authorized will be processed by the TPA at the discretion of the Company.

12) An INSURED PERSON may choose to seek hospitalization either at a Network or Non-Network Hospital.

13) For hospitalisations at Network Hospitals which have been duly pre-authorized as aforesaid, the INSURED PERSON will be eligible for credit facilities subject to fulfilling the eligibility criteria laid down by the TPA/Company from time to time or as may be set out in the provisions of Membership Guide in force.

14) For credit hospitalisations as referred to in clause 13 hereinabove, it shall be the responsibility of the INSURED PERSON to pay all expenses that are not eligible for payment as per the terms, conditions and exclusions of the policy and any endorsements thereto and the Company shall have no liability in that behalf.

15) For credit hospitalisations, the bills/supporting documents will be forwarded to the TPA by the Network Hospital. However, pre and post hospitalisation bills will be required to be forwarded to the TPA by the INSURED PERSON.

16) For non-credit hospitalizations, the bills will be required to be settled by the INSURED PERSON and thereafter sent along with relevant supporting documents to the TPA in support of a claim.

17) To be eligible to be considered by the TPA/Company, the duly completed claim form must be supported by all original documents / bills.

18) For Non-Network hospitalizations, an INSUREDPERSON shall make co-payment of 10 percent of admissible claim amount. The co-payment amount shall be deducted from the claims reimbursable and the balance shall be paid to the INSURED PERSON or INSURED PERSON at the sole discretion of the TPA / Company.

19) FOR THE REMOVAL OF DOUBTS IT IS EXPRESSLY CLARIFIED THAT IN THE EVENT OF A CONFLICT BETWEEN ANY RULES, REGULATIONS, REQUIREMENTS, STIPULATIONS, AUTHORIZATIONS, CONDITIONS OR WARRANTIES ISSUED / MADE / REQUESTED BYTHE TPA AND THE COMPANY, THOSE MADE BYTHE COMPANY SHALL PREVAIL.

Terms of renewal

a. **Lifelong Renewal**- We offer life-long renewal unless the Insured Person or any one acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or any misrepresentation under or in relation to this policy or the Policy poses a moral hazard.

b. **Grace Period** - Grace Period of 30 days for renewing the Policy is provided under this Policy.

c. **Renewal Premium** – Renewal premium are subject to change with prior approval from IRDA.Any change in benefits or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated atleast 3 months in advance.

d. In the likelihood of this policy being withdrawn in future, intimation will be sent to insured person about the same 3 months prior to expiry of the policy. Insured Person will have the **option to migrate to any health insurance policy available with us** at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDA.

e. Any Insured Person in the policy has the **option to migrate to any health insurance policy available with us at the time of renewal** subject to underwriting with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDA

Tax Benefit:

f. The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

Requirement

a. Completed proposal form

Discounts

Family Discount: The family discount of 10% to 20% in the total premium will be allowed comprising the Insured and any one or more of the following:

a) Spouse
b) Dependent Children
c) Dependent Parents

- If 2 persons are covered in one policy, then a discount of 10% is allowed.
- Up to 4 persons in one policy, then a discount of 15% is allowed.
- Beyond 4 persons in one policy, then there will be 20% discount.

Loadings

- We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the policy including subsequent renewal(s) with us or on the receipt of the request of enhancement in sum insured (for the enhanced Sum Insured).
- We will not apply any additional loading on your policy premium at renewal based on claim experience
- We will inform you about the applicable risk loading through a counter offer letter. You need to revert to us with consent and additional premium (if any), within 15 days of the issuance 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.
- Please note that we will issue policy only after getting your consent.

Termination

The Company may, at any time, cancel this policy by sending the INSURED PERSON thirty (30) days notice by registered letter at the INSURED PERSON'S last known address and in such event the Company shall refund to the INSURED PERSON a pro-rata premium for the unexpired Period of Insurance. The Company shall, however, remain liable for any claim, which arose prior to the date of cancellation.

The INSURED PERSON may at any time cancel the policy by sending the Company thirty (30) days notice by registered letter and in such event the Company shall retain premium at the Company's short period rate given herein below and refund the balance premium provided no claim has occurred up to the date of cancellation. If a claim is made under the policy, the Company will retain the entire premium.

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED
Upto one month	¼ of the annual rate
Upto three months	½ of the annual rate
Upto six months	¾ of the annual rate
Exceeding six months	Full annual rate

Premium Rates

a. The premium under individual coverage will be charged on the completed age of the individual insured member.
b. The premium under family floater coverage will be charged basis the completed age of the eldest insured member.
c. Premium rates are subject to change with prior approval from IRDA.
d. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.
e. Please note that your premium at renewal may change due to a change in your age or changes in the applicable tax rate

4 Rating Sheet-New Healthwise-Individual

Anti-Rebating Warning:

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance policy 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 the 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 published prospectus or tables of the insurer. Violations of Section 41 of the Insurance Act 1938, as amended, shall be punishable with a fine which may extend to Rs. 10 Lakhs.

IRDA REGULATION NO 5- This policy is subject to regulation 5 of IRDA (Protection of Policyholder's Interests) Regulation.

Disclaimer

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

Insurance is the subject matter of solicitation

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