

POLICY WORDING – GROUP ASSURANCE HEALTH PLAN

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

Section. 1. Inpatient Benefit

This section of benefits is applicable when

- An Insured Person suffers an Accident or Illness, which is covered under this Policy; AND
- Hospitalisation is necessary & is done for treatment OR
- Day care treatment is necessary and is done OR
- Domiciliary Hospitalization is necessary and is done for treatment

We will cover the Medical Expenses for:	We will not cover treatment, costs or expenses for*: *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section 2.
a. In-patient Treatment. This includes <ul style="list-style-type: none"> • Hospital room rent or boarding • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures. 	■
b. Pre-Hospitalisation Pre-Hospitalization Medical Expenses for consultations, investigations and medicines incurred upto 30 days before the date of admission to the Hospital This is applicable for In-patient treatment, Day Care treatment, or Domiciliary treatment.	i) Claims which have NOT been admitted under 1 a),1d) and 1e) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
c. Post-Hospitalisation Post Hospitalization Medical Expenses for consultations, investigations and medicines incurred upto 60 days after discharge from the Hospital. This is applicable for In-patient treatment, Day Care treatment, or domiciliary treatment.	i) Claims which have NOT been admitted under 1 a),1 d) and 1e) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.

Important terms You should know

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

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

Medical Practitioner means 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 its scope and jurisdiction of license.

<p>d. Day Care Treatment: Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours because of technological advancement. Treatment normally taken on out-patient basis is not included in the scope of this definition.</p>	<p>i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) Treatment NOT taken at a Hospital or a Day Care centre.</p>
<p>e. Domiciliary Hospitalisation: Medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii. The patient takes treatment at home on account of non-availability of room in a Hospital</p>	<p>i) Treatment of less than 3 days. ii) Expenses for treatment for first three days only will be covered if treatment period is greater than 3 days)</p>
<p>f. Organ Donor: Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an Insured Person while donating an organ is NOT covered.</p>	<p>i) Claims which have NOT been admitted under 1a) for the insured person. ii) Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). iii) The organ donor's Pre and Post-Hospitalisation expenses.</p>
<p>g. Ambulance Cover: Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to a maximum of Rs. 2000 per Hospitalisation.</p>	<p>i) Claims which have NOT been admitted under Section 1a) and 1d) ii) Healthcare or ambulance service provider not registered with road traffic authority.</p>

Important terms You should know

Day Care Treatment means medical treatment, and/or surgical procedure listed in Annexure 1 which is:

- i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
 - ii. which would have otherwise required hospitalization of more than 24 hours.
- Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii) the patient takes treatment at home on account of non-availability of room in a hospital.

Any claims made under the above mentioned benefit is subject to Inpatient Sum Insured

Section 2. Special Terms and Conditions

A. Waiting Period

All Illnesses, treatments and their associated complications shall be covered subject to the waiting periods specified below:

- i) 30-day waiting period
 - a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
 - b) This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.
 - c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

- ii) Specified Disease/Procedure waiting period
 - a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident or underlying cause is cancer(s).
 - b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
 - c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
 - d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
 - e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability/migration stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
 - f) List of specific diseases/procedures: -

Sl No	Organ / Organ System	Illness/diagnoses (irrespective of treatments medical or surgical)	Surgeries/procedures (irrespective of any illness / diagnosis other than cancers)
a.	Ear, Nose and Throat (ENT)	<ul style="list-style-type: none"> ▪ Sinusitis ▪ Rhinitis ▪ Tonsillitis 	<ul style="list-style-type: none"> ▪ Adenoidectomy ▪ Mastoidectomy ▪ Tonsillectomy ▪ Tympanoplasty ▪ Surgery for nasal septum deviation ▪ Surgery for Turbinate hypertrophy ▪ Nasal concha resection ▪ Nasal polypectomy
b.	Gynaecological	<ul style="list-style-type: none"> ▪ cysts, polyps including breast lumps ▪ Polycystic ovarian disease ▪ Fibromyoma ▪ Adenomyosis ▪ Endometriosis ▪ Prolapsed Uterus 	<ul style="list-style-type: none"> ▪ Hysterectomy
c.	Orthopaedic	<ul style="list-style-type: none"> ▪ Non infective arthritis ▪ Gout and Rheumatism ▪ Osteoarthritis ▪ Ligament, Tendon and Meniscal tear ▪ Prolapsed inter vertebral disk 	<ul style="list-style-type: none"> ▪ Joint replacement surgeries

d.	Gastrointestinal	<ul style="list-style-type: none"> • Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess <ul style="list-style-type: none"> ▪ Rectal Prolapse 	<ul style="list-style-type: none"> • Cholecystectomy ▪ Surgery of hernia
e.	Urogenital	<ul style="list-style-type: none"> • Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate <ul style="list-style-type: none"> ▪ Varicocele 	<ul style="list-style-type: none"> • Surgery on prostate ▪ Surgery for Hydrocele/ Rectocele
f.	Eye	<ul style="list-style-type: none"> ▪ Cataract ▪ Retinal detachment ▪ Glaucoma 	<ul style="list-style-type: none"> ▪ NIL
g.	Others	<ul style="list-style-type: none"> ▪ NIL 	<ul style="list-style-type: none"> ▪ Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs whether or not described above)	<ul style="list-style-type: none"> ▪ Benign tumors of Non infectious etiologie.g. cysts, nodules, polyps, lump, growth, etc. 	<ul style="list-style-type: none"> ▪ NIL

iii. Pre-Existing Diseases

- a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the insured person is continuously covered without any break as defined under the portability/migration norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

Important terms You should know

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

- a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
- b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

B. General Exclusions

We will not pay for any claim which is caused by, arising from or attributable to following including their associated complications

<p>Non Medical Exclusions</p>	<p>1. War or similar situations: Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.</p> <p>2. Breach of Law: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.</p> <p>3. Intentional self-injury or attempted suicide while sane or insane.</p> <p>4. Hazardous or Adventure sports Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.</p>
<p>Medical Exclusions</p>	<p>1. Investigation & Evaluation:Code Excl04</p> <ul style="list-style-type: none"> a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded. b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded. <p>2. Rest Cure, rehabilitation and respite care–Code – Excl05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:</p> <ul style="list-style-type: none"> a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons. b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs. <p>3. Obesity/Weight control:Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:</p> <ul style="list-style-type: none"> a. Surgery to be conducted is upon the advice of the doctor b. The surgery/procedure conducted should be supported by clinical protocols c. The member has to be 18 years of age or older and d. Body Mass Index (BMI) <ul style="list-style-type: none"> i. Greater than or equal to 40 or, ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: <ul style="list-style-type: none"> 1. Obesity related cardiomyopathy 2. coronary heart disease 3. severe sleep apnoea 4. uncontrolled type2 diabetes <p>4. Change-of-Gender treatments - Code – Excl07:Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.</p>

5. **Cosmetic or plastic surgery:**Code – Excl08:Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of **Medically Necessary Treatment** to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending **Medical Practitioner**.
6. **Hazardous or Adventure Sports**Code – Excl09– Expenses related to any treatment necessitated due to participation as a professional in **Hazardous** or **Adventure sports**, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.
7. **Breach of Law:**Code – Excl10 - Expenses for treatment directly arising from or consequent upon any **Insured Person** committing or attempting to commit a breach of law with criminal intent.
8. **Excluded Providers-** Code – Excl11 Expenses incurred towards treatment in any hospital or by any **Medical Practitioner** or any other provider specifically excluded by the **Insurer** and disclosed in its website/notified to the policyholders are not admissible. However, in case of **life threatening situations** or following an **Accident**, expenses up to the stage of stabilization are payable but not the complete claim.
9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12
10. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.Code – Excl13
11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a **Medical Practitioner** as part of **Hospitalization** claim or day care procedure.Code – Excl14
12. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.Code – Excl15
13. **Unproven Treatments–** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.Code – Excl16
14. **Sterility and Infertility –**Code – Excl17 -Expenses related to sterility and infertility. This includes:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c. Gestational Surrogacy
 - d. Reversal of sterilization
15. **Maternity:**Code – Excl18
 - a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.
16. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, **Nuclear, Chemical** or **Biological** attack or weapons, radiation of any kind.
17. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
18. Any **Insured Person's** participation or involvement in naval, military or air force operation.
19. Investigative treatment for Sleep-apnoea, General debility or exhaustion (“run-down condition”).
20. Congenital external diseases, defects or anomalies,

	<ol style="list-style-type: none"> 21. Stem cell harvesting. 22. Investigative treatments for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities). 23. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment). 24. Any Convalescence, ,sanatorium treatment, private duty nursing or long-term nursing care. 25. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. 26. Vaccination including inoculation and immunisations (Except post Animal bite treatment), 27. Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergohealth.com. 28. Treatment taken on Outpatient basis 29. The provision or fitting of hearing aids, spectacles or contact lenses. 30. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, Optometric therapy. 31. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription. 32. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively), prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergohealth.com 33. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form. 34. Non Allopathic treatments
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Section 3 General Conditions

a. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

b. Disclosure of Information

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

c. Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India.

d. Insured Person

Only those persons named as Insured Persons in the Schedule/Certificate of Insurance shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

Any Insured Person in the Policy has the option to migrate to similar indemnity health insurance Policy available with Us at the time of renewal subject to underwriting with all the accrued continuity benefits such as waiver of waiting period etc. provided the Policy has been maintained without a break as per portability/migration guidelines.

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

e. Notification of Claim

	Treatment, Consultation or Procedure:	We or Our TPA must be informed:
i)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency:	Within 24 hours of the Insured Person's admission to Hospital.
iii)	For all benefits which are contingent on Our prior acceptance of a claim under Section 1)a):	Within 7 days of the Insured Person's discharge post-hospitalisation.

e. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We/ TPA must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
i)	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation
ii)	If any treatment, consultation or procedure for which a claim may be made to be taken in an	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network	Within 24 hours after the treatment or Hospitalisation

	Emergency:		Hospital.	
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f. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include to the following: Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/reports which are not listed below:

- i) Our claim form, duly completed and signed for on behalf of the Insured Person.
- ii) Original Bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
- iii) All reports and records, including but not limited to all medical reports, case histories/indoor case papers on case to case basis if required, investigation reports, treatment papers, discharge summaries.
- iv) A precise diagnosis of the treatment for which a claim is made.
- v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).
- vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor's invoice.
- vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
- viii) All investigation, treatment and follow up records pertaining to the past ailment(s) related to the claim since their first diagnoses or detection on a case to case basis.
- ix) Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
- x) Copy of settlement letter from other insurance company or TPA
- xi) Stickers and invoice of implants used during surgery
- xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
- xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
- xiv) Legal heir certificate

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

h. Claims Payment

- i) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

- ii) We will only make payment to Insured Person under this Policy. Receipt of payment by Insured Person shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Insured Person's death, We will make payment to the Nominee (as named in the Schedule/Certificate of Insurance), payments under this Policy shall only be made in Indian Rupees within India.
- iii) The assignment of benefits payable under this Policy shall be subject to applicable law.
- iv) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an emergency.
- v) Provision for Penal Interest
 - a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
 - b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
 - c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
 - d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

i. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

j. Portability

The **Insured Person** will have the option to port the Policy to other insurers by applying to such **Insurer** to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

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

k. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without

any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link

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

I. Moratorium Period:

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

m. Non-Disclosure or Misrepresentation:

- i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:
 - a) cancelled ab initio from the inception date or the renewal date (as the case may be), at Our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance or the Policy may be modified with the consent of the customer
 - b) the claim under such Policy if any, shall be rejected/repudiated forthwith
- ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;
 - a) Permanently exclude the disease/condition and continue with the Policy
 - b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
 - c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

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

n. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be

true;

- b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

o. Multiple Policies

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

p. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

q. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover **or**

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

r. Renewal of Policy

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

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience.
 - a)

s. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

t. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

u. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

v. Notices

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

- i) Any Insured Person, it would be sent to You at the address specified in Schedule/endorsement/Certificate of Insurance.
- ii) Us, shall be delivered to Our address specified in the Schedule/Certificate of Insurance.
- iii) No insurance agents, brokers, other person/ entity unless authorised by Us is authorised to receive any notice on Our behalf.

w. Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

x. Cancellation

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

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

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

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

Section 4. Other Important Terms You should know

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

- Def. 1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
- Def. 2. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an **Insured Person** participates or competes for entertainment or as part of his Profession whether he / she is trained or not.
- Def. 3. **Associated Medical Expenses** means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person
- Def. 4. **Administrator** means any entity/person(s) engaged by the Insurer for providing Policy and claims facilitation services to the Insured as well as to Us.
- Def. 5. **Age or Aged** means completed years as at the Commencement Date.
- Def. 6. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was been taken.
- Def. 7. **AYUSH HOSPITAL** means an AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner(s)* comprising of any of the following:
- Central or State Government AYUSH Hospital; or
 - Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or
 - AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:
 - Having at least 5 in-patient beds;

- ii. Having qualified *AYUSH Medical Practitioner* in charge round the clock;
- iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 8. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered *AYUSH Medical Practitioner(s)* on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered *AYUSH Medical Practitioner (s)* in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 9. **Bank Rate** shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 10. **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 is approved.

Def. 11. **Commencement Date** means the commencement date of this Policy as specified in the Schedule/Certificate of Insurance.

Def. 12. **Condition Precedent** means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

Def. 13. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position

- (a) Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body
- (b) External Congenital Anomaly- Congenital Anomaly which is in the visible and accessible parts of the body

Def. 14. **Co-payment** means a cost sharing requirement under a health insurance Policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

Def. 15. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 16. **Critical Illness means** any one of the following illnesses or conditions that occurs or manifests itself during the Policy Period as a first incidence and the insured survives the defined survival period

a) **Cancer of specified severity**

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

- i) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- ii) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- iii) Malignant melanoma that has not caused invasion beyond the epidermis;
- iv) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi) Chronic lymphocytic leukaemia less than RAI stage 3
- vii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- viii) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- ix) All tumors in the presence of HIV infection.

b) Open Chest CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- II. The following are excluded:
 - (i) Angioplasty and/or any other intra-arterial procedures

c) Myocardial Infarction (First heart attack of specific severity)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
 - ii) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
 - iii) New characteristic electrocardiogram changes
 - iv) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. The following are excluded:
 - i) Other acute Coronary Syndromes
 - ii) Any type of angina pectoris
 - iii) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

d) Kidney Failure Requiring Regular Dialysis

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

e) Major Organ/Bone Marrow Transplant

- I. The actual undergoing of a transplant of:
 - i) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

- ii) Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
 - II. The following are excluded:
 - i) Other stem-cell transplants
 - ii) Where only islets of langerhans are transplanted
- f) Multiple Sclerosis with Persisting Symptoms**
- I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - i) investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - ii) there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
 - II. Other causes of neurological damage such as SLE and HIV are excluded.
- g) Permanent Paralysis of Limbs**
- I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.
- h) Stroke resulting in Permanent Symptoms**
- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
 - II. The following are excluded:
 - i) Transient ischemic attacks (TIA)
 - ii) Traumatic injury of the brain
 - iii) Vascular disease affecting only the eye or optic nerve or vestibular functions.
- i) Open Heart Replacement or Repair of Heart Valves**
- I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or diseaseaffected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.
- j) Coma of Specified Severity**
- I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
 - i. no response to external stimuli continuously for at least 96 hours;
 - ii. life support measures are necessary to sustain life; and
 - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

- II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

k) Motor Neuron Disease with Permanent Symptoms

- I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

l) Major Head Trauma

- I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
- II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.
- III. The Activities of Daily Living are:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.
- IV. The following are excluded:
 - i. Spinal cord injury;

Def. 12. Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

- i) has qualified nursing staff under its employment;
- ii) has qualified medical practitioner/s in charge;
- iii) has fully equipped operation theatre of its own where surgical procedures are carried out;

iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 13. **Day Care Treatment** means those medical treatment, and/or *surgical procedure listed in Annexure 1:*

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

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

Def. 14. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 15. **Deductible** means a cost sharing requirement under a health insurance Policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def. 16. **Dependents** means only the family members listed below:

- i) Your legally married spouse as long as she continues to be married to You;
- ii) Your children Aged between 91 days and 25 years if they are unmarried
- iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Group Assurance Health Plan Insurance Policy.
- iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Group Assurance Health Plan Insurance Policy.
- v) All Dependent parents must be financially dependent on You.

Def. 17. **Dependent Child** means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 18. **Disclosure to information norms** means that the Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 19. **Domiciliary Hospitalisation** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

Def. 20. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured Person's health.

Def. 21. **Family Floater** means a Policy described as such in the Schedule/Certificate of Insurance where under You and Your Dependents named in the Schedule/Certificate of Insurance are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 22. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

Def. 23. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

- i) has qualified nursing staff under its employment round the clock;
- ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patientbeds in all other places;
- iii) has qualified medical practitioner(s) in charge round the clock;
- iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

Def. 24. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 25. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition - 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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Def. 26. **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.

Def. 27. **In-patient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

Def. 28. **Insured Person means** You and the persons named in the Schedule/Certificate of Insurance.

Def. 29. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 30. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the coverage for bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing, and intensive charges.

Def. 31. **Material Facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 32. **Maternity expenses** means—

- b) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- c) expenses towards lawful medical termination of pregnancy during the Policy Period.

Def. 33. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Def. 34. **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.

Def. 34. **Medical Practitioner** means 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 its scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured Person's and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 35. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

- i) is required for the medical management of the illness or injury suffered by the insured;
- ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
- iii) must have been prescribed by a medical practitioner;
- iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 36. **Migration** means the right accorded to individual health insurance policyholders (including all members under family cover and members of group health insurance policy) to transfer the credits gained for pre-existing conditions and time-bound exclusions, with the same insurer.

Def. 37. **Network Provider** means Hospital enlisted by an insurer or a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility

Def. 38. **New born baby** means baby born during the Policy Period and is aged upto 90 days.

Def. 39. **Non Network Provider** means any Hospital, day care centre or other provider that is not part of the Network

- Def. 40. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- Def. 41. **OPD Treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
- Def. 42. **Portability** means the right accorded to an individual health insurance Policyholders (including all members under family cover) to transfer the credits gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.
- Def. 43. **Pre-existing Disease** means any condition, ailment, injury or disease:
- a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
 - b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
- Def. 44. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
- i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - (a) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- Def. 45. **Post-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:
- i) Such Medical Expenses are 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 the insurance company.
- Def. 46. **Preventive Health Check-up** means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.
- Def. 47. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this Policy wording (including endorsements, if any) and the Policy Schedule (as the same may be amended from time to time).
- Def. 48. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule/Certificate of Insurance. For **Insured Person** it means **Period of Insurance** as specified in the Certificate of Insurance or Endorsement.
- Def. 49. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.
- Def. 50. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- Def. 51. **Reasonable & 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, taking into account the nature of the illness / injury involved.

- Def. 52. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
- Def. 53. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the **Associated Medical Expenses**.
- Def. 54. **Shared Accommodation** means hospitalisation in a Hospital room with two or more In-patient beds
- Def. 55. **Survival period** means the period after an insured event that the Insured Person has to survive before a claim is payable
- Def. 56. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
- Def. 57. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule/Certificate of Insurance.
- Def. 58. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
- Def. 59. **We/Our/Us** means the HDFC ERGO Health Insurance Limited.
- Def. 60. **You/Your/Policyholder** means the person named in the Schedule/Certificate of Insurance who has concluded this Policy with Us.

Section 5. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, the Insured Person can contact HDFC ERGO Health through:

- Website : www.hdfcergohealth.com
- Toll Free : 1800-102- 0333
- Fax : 1800- 425- 4077
- Courier : Claims Department,
HDFC ERGO Health Insurance Ltd
Ground floor, Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad-500 034

Or

Claims Department
HDFC ERGO Health Insurance Limited
iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, UdyogVihar, Phase – III,
Gurgaon -122016, HARYANA

Section 6. Redressal of Grievance

In case of any grievance the insured person may contact the company through

- Our website : www.hdfcergohealth.com
- E-mail : customerservice@hdfcergohealth.com
- E-mail specific for Senior citizens : seniorcitizen@hdfcergohealth.com
- Toll Free : 1800-102-0333
- Fax : +91-124-4584111
- Courier : Any of Our Branch office or Corporate office

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

The Grievance Cell, HDFC ERGO Health Insurance Limited, iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, UdyogVihar, Phase – III, Gurgaon -122016, HARYANA

For updated details of grievance officer, kindly refer the link: <https://www.hdfcergohealth.com/escalate-your-case.aspx>

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

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD - ShriKuldip Singh Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, JeevanSoudhaBuilding, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203	Madhya Pradesh Chattisgarh.

Office Details	Jurisdiction of Office (Union Territory, District)
Email: bimalokpal.bhopal@ecoi.co.in	
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - ShriSudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - ShriKiriti .B. Saha Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.

Office Details	Jurisdiction of Office (Union Territory, District)
Email: bimalokpal.hyderabad@ecoi.co.in	
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW - Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road,	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura,

Office Details	Jurisdiction of Office (Union Territory, District)
<p>Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in</p>	<p>Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>
<p>PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in</p>	<p>Bihar, Jharkhand.</p>
<p>PUNE - ShriVinaySah Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in</p>	<p>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</p>

Annexure I - List of Non-Medical Expenses

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLEY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE

34	WALKING AIDS CHARGES	68	VASOFIX SAFETY
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IRDA REGULATION NO 12: This Policy is subject to regulation 12 of IRDA (Protection of Policyholder's Interests) Regulation 2017.

