MAXIMA INSURANCE

HDFC ERGO Health Insurance Limited will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the terms and conditions of this Policy, Your payment of premium, and Your statements in the Proposal, which is incorporated into the Policy and is the basis of it.

Part A – Outpatient Module

Claims made in respect of any of the benefits in this Part A will not be subject to the Sum Insured and will affect the entitlement to a Carry Forward Bonus.

However,Our maximum liability for each benefit in Section 1 to this Part A shall be limited to the amount specified in the Schedule of Benefits against such benefit.An Insured Person shall only be eligible to take the treatment, consultation or procedure under aPart A, Section 1 benefit if all of the following requirements are satisfied:

a) We have issued an Entitlement Certificate to the Insured Person for the specific treatment, consultation or procedure; and

b) The Entitlement Certificate is used for the specific treatment, consultation or procedure specified in it; and

c) Any conditions or limitations specified in the Entitlement Certificate are strictly adhered to; and

d) The Entitlement Certificate is used (and will only be effective) at only a Network service provider; and

e) The Insured Person gives the Entitlement Certificate to the Network service provider before receivingor undergoing the treatment, consultation or procedure specified in it.

f) The treatment, consultation or procedure specified in the Entitlement Certificate is taken or undergone by the Insured Person during the Policy Period.

g) The payment of premium in full and in time.

h) If an Entitlement Certificate has been used and results in treatment to which Part B responds, then it is agreed and understood that We would be refunding the Entitlement Certificate used for pre-hospitalisation by issuing fresh Entitlement Certificate.

Section 1 Outpatient Benefits

An Entitlement Certificate may be obtained by the Insured Person for his own use for one of the specified treatments, consultations or procedures under a benefit mentioned in a) – f) below:

a) Outpatient Consultations

Outpatient consultation by a general Medical Practitioneror a specialist Medical Practitioneras further specified in the Entitlement Certificate in a Network Hospital.

i. The non-network Outpatient consultations will be covered on reimbursement basis subject to the number of consultations and the amount specified in the Schedule of Benefits.

b) Diagnostic Tests

Outpatient diagnostic tests taken by the Insured Person from a diagnostic centre(not necessarily to be prescribed by Network Medical Practitioner).

c) **Pharmacy**

Medicines purchased by the Insured Person from a pharmacy, provided that such medicines have been prescribed in writing by a Medical Practitioner(not necessarily to be Network Medical Practitioner).

d) **Outpatient Dental Treatment**

Any necessary dental treatment taken by an Insured Person from dentist,

i. provided that We will not pay for any dental treatment that comprises cosmetic treatment and

ii. the benefit amount is restricted to Rs. 1,000 per Policy Year

e) **Spectacles, Contact lenses**

Either one pair of spectacles or contact lenses,as specified in the Entitlement Certificate provided that these have been prescribed for the Insured Person by a Eye specialist Medical Practitioner.

f) Annual Health Check-Upwithin specified Network

A health check-up as specified in the Schedule of Benefits for the Insured Person within Network.

This benefit is not available to the Insured Persons below 18 years of age and above the age of 45 years in the first Policy Year with Us

Section. 2 Carry Forward Bonus

a) If the Policy is renewed with Us without any break and there are any available Entitlement Certificatesare not used by the Insured Person in a Policy Year, then We will carry forward 50% of these Entitlement Certificates to the next Policy Year.

b) It is expressly agreed and understood that:

i) A carry forward will only apply in respect of any particular Entitlement Certificate for one Policy Year; and

ii) There shall be no carry forward of any Entitlement Certificate for the benefit at Section 1)f) of Part A.

iii) There will be no Carry Forward Bonus unless the originals of all unused Entitlement Certificates are returned to us before renewal (grace period of 15 days from the due date of renewal).

iv) For the purpose of computing carry forward of any Entitlement Certificate; in the event of unused Entitlement Certificates received are in odd number, We will round them off to next increased number.

c) To obtain carry forward Entitlement Certificates, You have to send us all unused Entitlement Certificates before renewal. After verifying the Entitlement Certificates and checking the admissibility of Carry Forward Bonus as mentioned above, fresh Entitlement Certificates will be issued within 30 days of the receipt of the unused Entitlement Certificates provided that the policy is renewed with Us without a break.

Part B – Inpatient Module

Section. 3 Inpatient Benefits

Claims made in respect of any of the benefits below will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's Hospitalisation as an inpatient, then We will pay:

a) **In-patient Treatment**

The Medical Expenses for:

i) Room rent, boarding expenses,

ii) Nursing,

iii) Intensive care unit,

iv) Medical Practitioner(s),

v) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,

vi) Medicines, drugs and consumables,

vii) Diagnostic procedures,

viii) The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

b) Pre-Hospitalisation Medical Expenses

The Medical Expenses incurred in the 30 days immediately before the Insured Person was Hospitalised, provided that:

i) Such Medical Expenses were in fact incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and

ii) We have accepted an inpatient Hospitalisation claim under Section 3a).

iii) We will pay the Medical Expenses incurred within the 60 days prior to the date of Hospitalisation, if we are provided with the following at least 5 days before the Hospitalisation:

iv) medical documents with all details about the Illness; and

v) the date and the place of the proposed Hospitalisation.

c) **Post-hospitalisation Medical Expenses**

The Medical Expenses incurred in the 60 days immediately after the Insured Person was discharged post Hospitalisation provided that:

i) Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalisation was required, and

ii) We have accepted an inpatient Hospitalisation claim under Section 3 a).

iii) We will pay the Medical Expenses in the 90 days immediately after the Insured Person was discharged if We were provided with the following at least 5 days before the Hospitalisation:

(1) medical documents with all details about the Illness; and

(2) the date and the place of the proposed Hospitalisation.

d) **Day Care Procedures**

The Medical Expenses for a day care procedure or surgery where the procedure or surgery is Undertaken under General or Local Anaesthesia in a **Hospital/Day Care Centre** in less than 24 hours because of technological advancement, and which would have otherwise required **Hospitalization** of more than 24 hours. Treatment normally taken on an Out-patient basis is not included in the scope of this definition

e) **Domiciliary Treatment**

The Medical Expenses incurred by an Insured Person for medical treatment taken at his home which would otherwise have required Hospitalisationbecause, on the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or a Hospital bed was unavailable, and provided that:

i) The condition for which the medical treatment is required continues for at least 3days, in which case We will pay the reasonable cost of any necessary medical treatment for the entire period, and

f) **Daily Cash for choosing Shared Accommodation**

Note: Claims made in respect of this benefit will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

A per day cash amount will be payable if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours, provided that:

i) Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and

ii) The days of admission and discharge shall not be counted, and

iii) This benefit shall not apply to time spent by the Insured Person in an intensive care unit, and

iv) We have accepted an inpatient Hospitalisation claim under Section 3 a).

g) **Organ Donor**

The Medical Expenses for an organ donor's treatmentfor the harvesting of the organ donated, provided that:

i) The organ donor is any person whose organ has been made available in accordance and in compliance withthe Transplantation of Human Organs Act 1994and the organ donated is for the use of the Insured Person, and

ii) We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment for the donor consequent on the harvesting, and

iii) We have accepted an inpatient Hospitalisation claim under Section 3 a).

h) **Emergency Ambulance**

We will reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service providerused to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention), provided that:

i. Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits per Hospitalisation, and

ii. We have accepted an inpatient Hospitalisation claim under Section 3 a).

iii. The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, provided that transportation has been prescribed by a Medical Practitioner and is medically necessary

i) **Daily Cash for Accompanying an Insured Child**

Note: Claims made in respect of this benefit will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

If the Insured Person Hospitalised is a child Aged 12 years or less, We will pay a daily cash amount for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours, provided that:

i) Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and

ii) The days of admission and discharge shall not be counted, and

iii) We have accepted an inpatient Hospitalisation claim under Section 3 a).

j) **Maternity Expenses**

Note: Claims made in respect of this benefit will not be subject to the Sum Insured and will not affect the entitlement to a cumulative bonus.

We will pay theMedical Expenses for a delivery (including caesarean section) while Hospitalised or the lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person, provided that:

i) Our maximum liability per delivery or termination shall be limited to the amount specified in the Schedule of Benefits, and

ii) We will pay the Medical Expenses of pre-natal and post-natal expenses per delivery or termination upto the amount stated in the Schedule of Benefits, and

iii) We will cover the Medical Expenses incurred for the medically necessary treatment of the infant baby upto the amount stated in the Schedule of Benefitsunless the infant baby is covered under Section 3k), and

iv) This benefit is not available for Dependents other than Your spouse under a Family Floater, and

v) Pre- and post-hospitalisation expenses under Section 3)b) and Section 3)c)are not covered under this benefit, and

vi) The Insured Person must have been an Insured Person under Our Policy for the period of time specified in the Schedule of Benefits, and

vii) We will not cover ectopic pregnancy under this benefit (although it shall be covered under Section 3a)).

k) **Newborn baby**

Note: This benefit is optional and effective only if noted as such in the Schedule of Benefits. The sum insured of this benefit is above the Maternity Sum Insured limit; will be equivalent to Individual Sum Insured [Rs. 300,000] under 1 Adult plan and Floater Sum Insured [Rs. 300,000] under 2 Adults & upto 2 Children plan.

We will cover the Medical Expenses of any medically necessary treatment described at Section 3a) while the Insured Person is Hospitalised during the Policy Period as an inpatient for a Newborn Baby provided that:

i) We have accepted a claim under Section 3j), and

ii) You have submitted a proposal for the insurance of the newborn baby within 30 working days after the birth, and We have in Our sole and absolute discretion accepted the same and received the premium sought.

Newborn Baby means those babies born to You and Your spouse during the Policy Period Aged between 1 day and 90 days.

Section. 4 Cumulative Bonus

a) If no claim has been made under the Policy and the Policy is renewed with Us without any break, We will apply a cumulative bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 10% of the Sum Insured for this Policy Year. The maximum cumulative bonus shall not exceed 50% of the Sum Insured in any Policy Year.

b) In relation to a Family Floater, the cumulative bonus so applied will only be available in respect of claims made by those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

c) If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the cumulative bonus by 20% of the Sum Insured in that following Policy Year.

Section. 5 Optional Benefit - Critical Illness

Claims made in respect of any of the benefits below will not be subject to the Sum Insured and will not affect entitlement to a cumulative bonus.

If the Schedule shows that the Critical Illness benefit is effective, then We will pay the Critical Illness Sum Insured as a lump sum in addition to Our payment under Section 3)a), provided that:

i) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and

ii) The Insured Person survives for at least 30 days following such diagnosis.

We will not make any payment if:

i) The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under a Maxima InsurancePolicy.

ii) The Insured Person has already made a claim for the same Critical Illness.

iii) A claim for this benefit has already been made 3 times under thisPolicy or any other policy issued by Us.

Section. 6Exclusions [Applicable to Part B only]

A. Waiting Periods

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

i) 30-day waiting period - Code Excl03

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

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

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

i. **Illnesses**: arthritis if non infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/fistula in anus, hemorrhoids, pilonidal sinus, gastric and duodenal ulcers; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant);

osteoarthritis and osteoporosis ; polycystic ovarian diseases; sinusitis and Rhinitis,Tonsilitis and skin tumors unless malignant.

ii. **Treatments:** benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy; joint replacement; myomectomy for fibroids; surgery of gallbladder and bile duct unless necessitated bymalignancy; surgery of genito urinary system unless necessitated by malignancy; surgery of benign prostatic hypertrophy; surgery of hernia; surgery of hydrocele; surgery for prolapsed inter vertebral disk; surgery of varicose veins and varicose ulcers; surgery on tonsils and sinuses; nasal septum deviation.

iii. Pre-Existing Diseases - Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the insured person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

B. General Exclusions

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

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

ii. **Rest Cure, rehabilitation and respite care: Code – Excl05** – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

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

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

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

viii. **Excluded Providers: Code11 -** Expenses incurred towards treatment in any hospital or by any **Medical Practitioner** or any other provider specifically excluded by the **Insurer** and disclosed in its website/notified to the policyholders are not admissible. However, in case of **life threatening situations** or following an **Accident,** expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

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

xiii. **Unproven Treatments: Code – Excl16 –** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

xiv. **Sterility and Infertility: Code- Excl17 –** Expenses related to sterility and infertility. This includes:
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization

xv. **Maternity: Code – Excl18**
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

xvi. War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection,military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

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

xviii. Any **Insured Person**'s participation or involvement in naval, military or air force operation.

xix. Investigative treatment for Sleep-apnoea,general debility or exhaustion ("run-down condition").

xx. Congenital external diseases, defects or anomalies,

xxi. Stem cell harvesting.

xxii. Investigative treatment for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

xxiii. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).

xxiv. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

xxv. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xxvi. Vaccination including inoculation and immunisations (Except post bite treatment),

xxvii. **Non-Medical expenses** such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges etc. Full list of Non-Medical expenses attached and is also available at www.hdfcergohealth.com.

xxviii. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family, or stays with him,

xxix. Treatment taken on Outpatient basis

xxx. The provision or fitting of hearing aids, spectacles or contact lenses.

xxxi. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement method. Optometric therapy.

xxxii. 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.

xxxiii. 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 crutchesand oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses attached and also available on www.hdfcergo.com.

xxxiv. Any Claim arising due to Non-disclosure of Pre-existing **Illness** or Material fact as sought to be declared on the Proposal form.

Part C: General Conditions

a) Condition precedentto 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) Insured Person

Only those persons named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

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 increase in Sum Insured (for the increased Sum Insured).

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.

c) Notification of Claim

	Treatment, Consultation or Procedure:	**We or Our TPA must be informed:**
1)	If any treatment under Part B 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.

2)	If any treatment under Part B 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.
3)	For all benefits which are contingent on Our prior acceptance of a claim under Section 3)a):	Within 7 days of the Insured Person's discharge post-Hospitalisation.
4)	If any treatment, consultation or procedure under Part B for which a claim may be made is required in an emergency:	Within 7 days of completion of such treatment, consultation or procedure.
5)	In all other cases:	Of any event or occurrence that may give rise to a claim under Part B of this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorise such treatment, consultation or procedure.

Please note that:

i) If any time period is specifically mentioned in Part B, then this shall supersede the time periods mentioned in 1)-5) above.

ii) Emergency means a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention.

d) <u>Cashless Service</u>:

	Treatment, Consultation or Procedure:	**Treatment, Consultation or Procedure Taken at:**	**Cashless Service is Available:**	**We must be given notice that the Insured Person wishes to take advantage of the cashless service**

				accompanied by full particulars:
1)	If any planned treatment, consultation or procedure for which a claim may be made under Part B:	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
2)	If any treatment, consultation or procedure for which a claim may be made under Part B is to be taken in an emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

Please note that emergency means a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention.

e) Supporting Documentation & Examination

i. The Insured Person shall provide Us with any documentation and information We or Our TPA may request to establish the circumstances of the claim under Part B, 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. Such documentation will include but is not limited to the following:

1. Our claim form, duly completed and signed for on behalf of the Insured Person.
2. 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.
3. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
4. A precise diagnosis of the treatment for which a claim is made.
5. A detailed list of the individual medical services and treatments provided and a unit price for each.

6. 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 Medical Practitioner's invoice if fees have been paid to that Medical Practitioner and are being claimed under the Policy.

ii. The Insured Person additionally hereby consents to:

1)The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.

2)Being examined by any doctor We authorise for this purpose when and so often as We may reasonably require and at Our cost.

f) Claims Payment

i. We shall be under no obligation to make any payment under Part B unless We have received all premium payments in full and 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 under Part B, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy. We shall be under no obligation to provide any benefit through an Entitlement Certificate under Section 1 Part A unless We have received all premium payments in full and in time and all payments have been realised and the Insured Person has given a valid and relevant Entitlement Certificate to the Network Service Provider before receiving any treatment, consultation or procedure under that Section. If the Entitlement Certificate has been used in any manner contrary to the requirements set out in the introduction to Part A, then We shall be entitled to deduct from any payment that is or may be due under Part B or any policy issued by Us and/or any premium subsequently received in respect of any policy issued by Us the value of the Entitlement Certificate and the costs and expenses as deducted by Us which We have incurred due to the unauthorised use of the Entitlement Certificate. It is agreed and understood that if We make any recovery from premium subsequently received then that premium shall be deemed to have been received short and it is further agreed and understood that the terms of this clause shall survive the termination of the Policy.

ii. We will only make payment under Part B to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of the death of You or an Insured Person, We will make payment to the Nominee (as named in the Schedule).

iii. This Policy only covers medical treatment under Part A and that part of medical treatment under Part B which is taken within India, and payments under Part B shall only be made in Indian Rupees within India.

iv. The assignment of benefits of the policy shall be subject to applicable law.

v. We are not obliged to make payment for any claim under Part B or that part of any claim under Part B that could have been avoided or reduced if the Insured Person had taken reasonable care or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

g) Claim settlement (Provision for penal interest)

- 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.
- 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.
- However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

h) 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.

i) 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 have 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.

i) Entitlement Certificate:

An Entitlement Certificate issued under Part A shall be used solely by the Insured Person named therein. The Insured Person shall not sell, exchange, trade, barter or transfer or allow any person to use his Entitlement Certificate. Any contravention of this condition shall be in addition to any remedies available to Us and shall also be deemed to constitute a failure to satisfy the requirements set out in Part A.

We will replace a lost Entitlement Certificate only when We are satisfied that it is lost. However, We reserve the right to make such investigations into and call for such evidence of the loss of the Entitlement Certificate at Your expense as We consider necessary before issuing a duplicate Entitlement Certificate. Any contravention of this condition shall be in addition to any remedies available to Us and shall also be deemed to constitute a failure to satisfy the requirements set out in Part A.

If the Policy is terminated for any reason, You shall immediately return all Entitlement Certificates issued to all Insured Persons. Any unreturned Entitlement Certificates shall cease to be valid on the date of termination. You shall indemnify and keep Us indemnified and hold Us harmless from and against any claims, costs, expenses, awards or judgments arising out of or in relation to such Entitlement Certificates. This Policy is deemed to incorporate General Condition j) from any previous policy issued by Us.

j) 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.

k) Alterations to the Policy

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

l) Renewal of Policy

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

i. The Company shall endeavour 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.

vi.

m) Change of Policyholder

If You do not renew the Policy the Insured Persons may apply to renew the Policy within 7 days of the end of the Policy Period provided that they have identified a new adult policyholder who is a member of their immediate family. If We accept such application and the premium for the renewed policy is paid on time, then the Policy shall be treated as having been renewed without any break in cover.

n) Notices

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

1. Any Insured Person, then it shall be sent to You at Your address specified in the Schedule and You shall act for all Insured Persons for these purposes.

2. Us, it shall be delivered to Our address specified in the Schedule. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

o) 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.

p) Non-Disclosure or Misrepresentation:

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

   a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule ; and
   b) the claim under such Policy if any, shall be prejudiced.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

   b) Permanently exclude the disease/condition and continue with the Policy
   c) 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.
   d) 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 O'i' above.

q) Migration

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

Detailed Guidelines on Migration are available at

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

r) 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.

s) 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.

Detailed Guidelines on Portability are available at
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

t) Cancellation

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.

1 Year Policy Period	
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.

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.

u) 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.

v) 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.

w) 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.

x) Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

y) 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;

Section. 7 Interpretations & Definitions

The terms defined below 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** or **Accidental** means a sudden, unforeseen and unexpected event caused by external, violent and visible means (but does not include any Illness) which results in physical bodily injury.

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. **Age** or **Aged** means completed years as at the Commencement Date.

Def. 4. **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. 5. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 6. **Congenital Anomaly** means a condition 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. 7. **Critical Illness** means Cancer, Coronary Artery (Bypass) Surgery, First Heart Attack (Myocardial Infarction), Kidney Failure (end stage renal disease), Major Organ Transplantation, Multiple Sclerosis, Paralysis and Stroke all as defined below only:

i) Cancer of specified severity:

a. 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.

b. 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 ofmetastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond theepidermis;

iv. All tumors of the prostate unless histologically classified as having aGleason score greater than 6 or having progressed to at least clinicalTNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNMClassification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically describedas TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified asT1N0M0 (TNM Classification) or below and with mitotic count of lessthan or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

ii) ***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:

(a) Angioplasty and/or any other intra-arterial procedures

iii) ***Myocardial Infarction (First Heart Attack of Specified 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:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. 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.

iv) <u>Kidney Failure requiring Regular Dialysis:</u>

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.

v) <u>*Major Organ/ Bone Marrow Transplant:*</u>

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.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

vi) <u>*Multiple Sclerosis with Persisting Symptoms*</u>:

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.

vii) <u>*Permanent Paralysis of Limbs*</u>:

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.

viii) *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

Def. 8. **Dependents**means only the family members listed below:

i) Your legally married spouse as long as he/she continues to be married to You;

ii) Your children Aged between 91 days and 21 years if they are unmarried, still financially dependant on You and have not established their own independent households;

iii) Your natural parents or parents that have legally adopted You, provided that:

a) The parent was below 65 years at his initial participation in the Maxima Insurance Policy, and

b) Parents shall not include Your spouse's parents.

Def. 9. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 10. **Entitlement Certificate** means the certificate We issue which will operate only as detailed in the introduction to the Part A, Section 1 benefits.

Def. 11. **Family Floater** means a Policy whereunder You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 12. **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 the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

Def. 13. **Hospitalization**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. 14. **Insured Person** means You and Your Dependants named in the Schedule.

Def. 15. **Illness/ Illnesses**means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period 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. 5. it recurs or is likely to recur

Def. 16. **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. 17. **Maternity Expenses**means
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during **Hospitalization**).
b. Expenses towards lawful medical termination of pregnancy during the policy Period.

Def. 18. **Medical Expenses** means those Reasonable and Medically Necessary expenses that an Insured Person has necessarily and actually incurred for medical treatment on the advice of a Medical Practitioner due to Illness or Accident and leading to consequent hospitalisation during the Policy Period.

Def. 19. **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 the 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. 20. **Migration** means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def. 21. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a **Cashless facility**.

Def. 22. **Non Network** means any **Hospital**, **Day Care Centre** or other provider that is not part of the Network

Def. 23. **OPD Treatment**. 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. 24. **Policy** means Your statements in the proposal form, this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def. 25. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 26. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 27. Portability means the right accorded to 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. 28. **Pre-existing Conditionmeans**any condition, ailment, injury or disease:

- 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
- 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. 29. **Pre-hospitalization Medical Expenses** means**Medical Expenses** incurred during pre-defined 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

ii. The In-patient **Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company

Def. 30. **Post-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined 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. 31. **Reasonable and Customary Charges**means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services ,taking into account the nature of **Illness**/ **Injury** involved.

Def. 32. **Shared Accommodation** means a Hospital room with two or more patient beds.

Def. 33. **Sum Insured**means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all Insured Persons during the Policy Period.

Def. 34. **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. 35. **TPA**means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 36. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

Def. 37. **We/Our/Us** means the HDFC ERGO Health Insurance Limited

Def. 38. **You/Your/Policyholder**means the person named in the Schedule who has concluded this Policy with Us.

Maxima Insurance - Schedule of Benefits

Sum Insured per Policy	1 Adult	2 Adults	2 Adults + 2 Children
Part A- Outpatient Module			
a.) Outpatient Consultations*	4 Consultations	6 Consultations	8 Consultations
b.) Diagnostic Tests#	Rs. 5,000	Rs. 5,500	Rs. 7,000
c.) Pharmacy#			
d.) Outpatient Dental Treatment #			
e.) Spectacles, Contact Lenses #			
f.) Annual Health Check-up within specified Network^	1 Entitlement Certificate	2 Entitlement Certificates	2 Entitlement Certificates

** The reimbursement against non-network Outpatient Consultations is restricted up to lower of actual expenses or Rs. 400.*

 # The reimbursement against non-network Diagnostic Tests, Pharmacy, Outpatient Dental Treatment, Spectacles, Contact Lenses is restricted up to lower of actual expenses or the Sum Insured mentioned above.

^ One Entitlement Certificate of Annual Health Check-up includes following tests: Hb, PCV, RBC, MCHC, MCV, MCH, Total WBC, Differential Count, ESR, PLT, Peripheral Smear, Complete Urine Analysis, GTT,Serum Calcium, Serum Creatinine, Lipid Profile (Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Triglycerides, Cardiac Risk Ratio), Liver Function Test (Total Protein, Albumin, Globulin, Total bilirubin, ALT, AST, GGTP), Blood group, ECG (Resting), X-ray (chest), Ultrasound (Upper abdomen screening), Consultation by General Physician, Consultation by Gynecologist, Consultation by General Physician.

Part B-Inpatient Module			
Sum Insured per Policy	**300,000**	**300,000**	**300,000**
1 a) In-patient Treatment	Covered		
1 b) Pre-Hospitalization	30 days; can be increased to 60 days		
1 c) Post-Hospitalization	60 days; can be increased to 90 days		
1 d) Day Care Procedures	Covered		
1 e) Domiciliary Treatment	Covered		
2a) Daily Cash for choosing Shared	Rs.500 per day, Maximum Rs.3,000		

Accommodation	
2 b) Organ Donor	Covered
2 c) Emergency Ambulance	upto Rs 2000 per hospitalisation
2 d) Daily Cash for accompanying an insured child	Rs 300 per day; Maximum Rs 9,000
3 Maternity Expenses ** Waiting Period 4 years	Normal Delivery- Rs15,000; Caesarean Delivery-Rs25, 000 (* Including Pre/Post Natal limit of Rs.1,500 and infant baby limit of Rs.2,000)
4 Newborn baby	Optional
Optional Benefit	
5 Critical Illness ** [Offered on Individual basis]	Rs 300,000
** Benefits do not dip into inpatient Sum Insured	

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.

Grievance may also be lodged at IRDAI Integrated Grievance Management System -https://igms.irda.gov.in/

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, Ist 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 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
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	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.

Office Details	Jurisdiction of Office Union Territory, District)
Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	
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 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. SandhyaBaliga Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363	Rajasthan.

Office Details	**Jurisdiction of Office Union Territory, District)**
Email: Bimalokpal.jaipur@ecoi.co.in	
ERNAKULAM - Ms. PoonamBodra 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, Sonbhabdra, 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 - ShriMilind 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	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun,

Office Details	Jurisdiction of Office Union Territory, District)
4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
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	Bihar, Jharkhand.
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	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

IRDA REGULATION NO 12: This Policy is subject to regulation 12 of IRDA (Protection of Policyholder's Interests) Regulation 2017.

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	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY