HDFC ERGO General Insurance Company Limited

Policy Wording
Optima Super

Table of Contents

HDFC ERGO General Insurance Company Limited

Policy Wording
Optima Super

Preamble

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

SECTION A. DEFINITIONS

1. Standard Definition

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 or Accidental** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2 **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 may have been taken.

Def. 3 **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:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or

c. 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:

i. 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. 4 **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. 5 **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

Def. 6 **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 7 **Congenital Anomaly:** An external congenital anomaly refers to a condition(s) which is present since birth, in the visible and accessible parts of the body, and which is abnormal in reference to form, structure or position.

a) Internal Congenital Anomaly

Which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly

b) External Congenital Anomaly

Which is in the visible and accessible parts o f the body is called External Congenital Anomaly.

Def. 8 **Day care centre** means a day care centre means any institution established for day care treatment of sickness and / or injuries or a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

- has qualified nursing staff under its employment
- has qualified medical practitioner (s) in charge
- has 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. 9 **Day Care treatments** means those medical treatment, and/or surgical procedure

i) Which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24hours because of technological advancement, and

ii) which would have otherwise required a Hospitalisation of more than 24 hours,

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

Def. 10 **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. F0r the purpose of this policy deductible shall apply on per year basis.

Def. 11 **Dental Treatment** means treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 12 **Disclosure to 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. 13 **Emergency or 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. 14 **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def. 15 **Hospital** means any institution in India established for In-patient Care and Day Care Treatment of sickness and/or injuries and which has been registered as a Hospital with the local authorities, under clinical establishments (Registration & Regulations) 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 those 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. 16 **Hospitalisation or Hospitalised** means admission in a Hospital for a minimum of 24 In patient care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 17 **Illness** 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:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needsongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

Def. 18 **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 19 **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. 20 **Insured Person** means You and the persons named in the Schedule.

Def. 21 **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. 22 **Maternity Expense / Treatment** means the expense / treatment that include the following Medical treatment Expenses:

i. Medical Expenses for a delivery (including complicated deliveries and cesarian sections) incurred during hospitalisation

ii. 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

iii. Pre-natal and Post-natal Medical Expenses for delivery or termination.

Def. 23 **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 24 **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.

a) Pre-Hospitalisation- Medical Expenses means the Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

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

b) Post-Hospitalisation- Medical Expenses means the Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

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

Def. 25 **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 26 **Medical Practitioner** means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his 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. 27 **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 28 **Network Provider** means Hospitals, or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

Def. 29 **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timeliness as well as the address / telephone number to which it should be notified.

Def. 30 **Non Network** means any Hospital, day care centre or other provider that is not part of the Network.

Def. 31 **OPD treatment** means the treatment 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. 32 **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

Def. 33 **Pre-existing Condition** means any condition, ailment, injury or disease:

1. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

2. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def. 34 **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the Nursing Council of any state in India.

Def. 35 **Reasonable 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. 36 **Room Rent** means the amount charged by a hospital for the deductibles occupying of a bed on per day (24 hrs) basis and associated medical expenses.

Def. 37 **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. 38 **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 of suffering orprolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 39 **Unproven/Experimental treatmen**t is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven.

2. Specific Definitions

Def. 1 **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. 2 **Age or Aged** means completed years as at the Commencement Date.

Def. 3 **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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 **Break in policy** means the period of gap that occurs at the end of the existing policy term/instaIlment premium due date, when the premium due for renewal on a given policy or instaIlment premium due is not paid on or before the premium renewal date or grace period.

Def. 6 **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. 7 **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 8 **Contribution** means essentially the right of an insurer to call upon other insurers, liable to the

same insured, to share the cost of an indemnity claim on a ratable proportion of sum insured. This clause shall not apply to any benefit offered on fixed benefit basis.

Def. 9 **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 unmarriedand financially dependent with no independent source of income.

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 Optima Super Policy, and

b) Parents shall not include Your spouse's parents. Dependant parents must be financially dependent on you.

Def. 10 **Dependent Child** means a child (natural or legally adopted), who is unmarried, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 11 **Family Floater** means a Policy described as such in the Schedule where under 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. Deductible under Family Floater will be applicable on Policy Year basis.Policy means your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure I and the Schedule (as the same may be amended from time to time).

Def. 12 **Network** means any such Hospitals, day care centre or other provider that We/ TPA have mutually agreed with, to provide services like cashless access to Insured Persons. The list is available with Us on our website (www.hdfcergohealth.com)and subject to amendment from time to time.

Def. 13 **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 14 **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 15 **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.

Def. 16 **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 17 **We/Our/Us** means the HDFC ERGO Health Insurance Ltd.

Def. 18 **You/Your/Policyholde**r means the person named in the Schedule who has concluded this Policy with Us.

Important terms You should know

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.

In-patient Treatment means treatment arising from Accident or Illness and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.

Day Care treatments means those medicaltreatment, and/or surgical procedure

(i) undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement, and

(ii) which would have otherwise required a Hospitalisation of more than 24 hours,

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

Out-patient treatment means the treatment 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.

A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount o f the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured, and for the purpose of this policy deductible shall apply on per year basis.

SECTION B. BENEFITS

The following benefits are available to all Insured Persons who suffer an illness or accident during the Policy Period which requires Hospitalisation on an inpatient basis or treatment defined as a Day Care Procedure. All claims under these benefits will be payable only if the aggregate of covered medical expenses, in respect to Hospitalisation (s) in a policy year is in excess of the Deductible stated in the Schedule. Occurrence of the same Illness after a lapse of 45days as stated above will be considered as fresh Illness for the purpose of this Policy.

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 C
1) In-Patient Treatment Treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables,	Prosthetics NOT implanted by surgery. Hospitalisation for evaluation, Investigation only. For example tests like electrophysiology study (EPS), holter monitoring, sleep study etc. are not payable. Treatment availed outside India. Treatment at a healthcare facility which is NOT a

diagnostic procedures. • Note pertaining specifically to AYUSH Treatments only: Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.	Hospital.
2) Pre-Hospitalization Medical expenses for consultations, investigations and medicines incurred upto 60 days before Hospitalisation. **3) Post-Hospitalization Medical expenses** for consultations, investigations and medicines incurred upto 90 days after discharge from Hospital.	1. Claims which have NOT been admitted under B1) and B4). 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required. 3. Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
4) Day Care Procedures Medical treatment, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre for less than 24 hours because of technological advancement, which would have otherwise required a hospitalisation of more than 24 hours.	1. Out-Patient Treatment. 2. Treatment at a healthcare facility which is NOT a Hospital.
5) Organ Donor Medical treatment of the organ donor for harvesting the organ i.e. including surgery to remove organs from a donor in the case of transplant surgery.	1. Claims which have NOT been admitted under B1). 2. Claims not covered under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
6) Ambulance Service Expenses incurred on an ambulance, subject to lower of actualexpenseor Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under B1) and B4). 2. Non registered healthcare or ambulance service provider ambulances.

SECTION C. EXCLUSIONS & WAITING PERIOD

1. Standard Waiting Period

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

i) 30-days 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 as mentioned in the table below 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/procedure:

S. No	Organ / Organ System	Illness	Treatment/Surgeries
a.	ENT	▪ Sinusitis ▪ Rhinitis ▪ Tonsillitis	▪ Adenoidectomy ▪ Mastoidectomy ▪ Tonsillectomy ▪ Tympanoplasty ▪ Surgery for nasal septum deviation ▪ Nasal concha resection
b.	Gynaecological	▪ Cysts, polyps including breast lumps ▪ Polycystic ovarian disease ▪ Fibroids (fibromyoma)	▪ Dilatation and curettage (D&C) ▪ Myomectomy for fibroids
c.	Orthopaedic	▪ Non infective arthritis ▪ Gout and Rheumatism ▪ Osteoarthritis and	▪ Surgery for prolapsed inter vertebral disk ▪ Joint replacement

		osteoporosis	surgeries
d.	Gastrointestinal	▪ Calculus diseases of gall bladder including Cholecystitis ▪ Pancreatitis ▪ Fissure/fistula in anus, hemorrhoids, pilonidal sinus ▪ Ulcer and erosion of stomach and duodenum ▪ Gastro esophageal reflux Disorder (GERD) ▪ Perineal abscesses ▪ Perianal abscesses ▪ All forms of cirrhosis (Please Note: All forms of cirrhosis due to alcohol will be excluded)	▪ Cholecystectomy ▪ surgery of hernia
e.	Urogenital	▪ Calculus diseases of urogenital system Example: kidney stone, urinary bladder stone. ▪ Benign Hyperplasia of prostate	▪ Surgery on prostate ▪ Surgery for hydrocele/ rectocele
f.	Eye	▪ Cataract	▪ NIL
g.	Others	▪ NIL	▪ Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs /disciplines whether or not described above)	▪ Internal tumors, cysts, nodules, polyps, skin tumors	▪ NIL

iii) Pre-existing disease: Code – Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage

after the date of inception of the first policy with insurer.

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

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

Important terms You should know

Pre-existing Conditionmeans any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. For which Medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or its reinstatement.

2. Standard General Exclusions

We will not pay for any claim in respect of any Insured Person caused by, arising from or attributable to:

Non Medical Exclusions	**1.** 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. **2.** 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.
Medical Exclusions	**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: **c.** Surgery to be conducted is upon the advice of the doctor **d.** The surgery/procedure conducted should be supported by clinical protocols **e.** The member has to be 18 years of age or older and **f.** 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 remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner. **vi)** 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. **vii)** Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12 **viii)** 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 **ix)** 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 **x)** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15 **xi)** 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 **xii)** Sterility and Infertility –Code – Excl17 -Expenses related to sterility and infertility. This includes: **a.** Any type of contraception, sterilization **a)** Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI **b)** Gestational Surrogacy **c)** Reversal of sterilization **i)** 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.

3. Specific General Exclusions

Non Medical Exclusions	**i.** 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 Biologicalattack or weapons, radiation of any kind. **ii.** Intentional self-injury or attempted suicide while sane or insane.
Medical Exclusions	**i)** Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound. **ii)** Any Insured Person's participation or involvement in naval, military or air force operation. **iii)** Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition"). **iv)** Congenital external diseases, defects or anomalies, **v)** Stem cell harvesting **vi)** 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). **vii)** Circumcisions (unless necessitated by Illness or Injury and forming part of treatment). **viii)** Any Convalescence, ,sanatorium treatment, private duty nursing or long-term nursing care. **ix)** 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. **x)** Vaccination including inoculation and immunisations (Except post Animal bite treatment), **xi)** 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. **xii)** Treatment taken on Outpatient basis **xiii)** The provision or fitting of hearing aids, spectacles or contact lenses. **xiv)** 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. **xv)** 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. **xvi)** 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.hdfcergo.com **xvii)** Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form. **xviii)** Any non-allopathic treatment except to the extent of coverage provided for under 'In-patient treatment' cover. **xix)** Dental treatment and surgery of any kind, unless requiring Hospitalisation **xx)** Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. **xxi)** Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. **xxii)** Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured.

SECTION D. GENERAL CONDITIONS

1. Standard General Terms

a) Conditions Precedent to Admission of Liability

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.

b) 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.

c) 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.

d) Claim Settlement (Provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 15 days from the

date of receipt of intimation.

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 intimation to the date of payment of claim at a rate 2% above the bank rate.

e) Cancellation

The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

i. The Company may cancel the Policy at any time on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud or non-disclosure or misrepresentation

ii. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s

iii. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

f) Free Look Period

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

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

g) 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.

h) Moratorium Period

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

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 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.

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) Renewal of Policy

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

i. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.

ii. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

iii. No loading shall apply on renewals based on individual claims experience

iv. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.

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

l) 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.

m) 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.

n) Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

o) 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.

p) Grievance Redressal Procedure

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

First Point of Contact	Call us at 022 6158 2020 / 022 6234 6234/www.hdfcergo.com
Level 1	For lack of a response or if the response provided does not meet your expectation, you can: 1. Write to The Complaints & Grievance Cell (C&G Cell) HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra 2. You can also write an email to grievance@hdfcergo.com 3. Call on 18002677444 (operational Monday - Saturday 9AM to 6PM)
Level 2	If you're not satisfied with the resolution or if no response was received within 15 days, you can: 1. Write to the Chief Grievance Officer HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra 2. You can also write an email to cgo@hdfcergo.com
Level 3	In case grievance is not resolved at the above escalation levels, you can also lodge an online complaint through the website of Council for Insurance Ombudsmen (CIO) www.cioins.co.in

Dedicated Helpline For	Email ID	Contact Number
Senior Citizen	seniorcitizen@hdfcergo.com	022 6158 2026
Women	-	022 6158 2055

You may also refer the Grievance Redressal Escalation matrix on our website https://www.hdfcergo.com/customer-voice/grievances

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://bimabharosa.irdai.gov.in

2. Specific General Terms

a. Policy Duration

The premium for the policy will remain the same for the Policy Period mentioned in the policy

schedule. The policy will be issued for a period for 1 or /2year(s) period based on Policy Period selected and mentioned on the Policy Schedule, the sum insured & benefits will be applicable on Policy Year basis

b. Geography

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

c. Insured Person

Only those persons named as Insured Persons in the Schedule 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 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 guidelines.

If an Insured Person dies, he will cease to be an Insured Person upon Us 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.

d. Loadings and Discounts

We may apply a risk loading on the premium payable (based on the declarations made in the proposal form and the health status of the persons proposed for insurance) at the Commencement Date or on any renewal of the Policy with Us or on the receipt of a request for enhancing the Sum Insured. The maximum risk loading applicable for an individual will not exceed 100% per diagnosis / medical condition and an overall risk loading of 150% per individual. 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 send You the applicable risk loading in writing. You shall give UsYour consent and the additional premium (if any), within 7 days of the issuance of Our letter. If You neither accept our letter nor revert to Us within 7 days, We will cancel Your application and refund the premium paid within the next 7 days. We will issue Policy only after getting Your consent.Please visit our nearest branch to refer our underwriting guidelines, if required.

We will provide a Family Discount of 10% if 2 or more members are covered under a single optima super policy. An additional discount of 7.5% will be provided if insured person is paying two year premium in advance as a single premium. These discounts shall be applicable at inception and renewal of the policy

e. Notification of Claim

	Treatment, Consultation or Procedure:	**HDFC ERGO Health 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.

Note:

i. In the case of a covered Hospitalisation, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with a copy of intimation made to the other insurer/reimbursement provider immediately on knowing that the Deductible is likely to be exceeded.

ii. if any time period is specifically mentioned in Section B& C, then this shall supersede the time periods mentioned above.

f. Cashless Service

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	Notice period for the Insured Person to take advantage of the cashless service*: *Written notice must be accompanied by full particulars.
	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.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
	Any treatment, consultation or procedure for which a claim may be made 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 of the start of the Insured Person's Hospitalisation.

g. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with any documentation, medical records and information HDFC ERGO Health may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the either 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. Such documentation will include but is not limited to the following:

i) Our claim form, duly completed and signed for on behalf of the Insured Person.

ii) Original bills with detailed breakup of charges (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) Original payment receipts

iv) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.

v) Discharge Summary containing details of , Date of admission and discharge, detailed clinical history, past history, procedure details and details of treatment taken

vi) Invoice/Sticker of the Implants.

vii) A precise diagnosis of the treatment for which a claim is made.

viii)A detailed list of the individual medical services and treatments provided and a unit price for each.

ix) Prescriptions that name the Insured Person andin 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.

x) Obstrition history/ Antenatal card

xi) Previous treatment record along with reports, if any

xii) Indoor case papers

xiii) Treating doctors certificate regarding the duration &etiology

xiv)MLC/ FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent, in case of Accidental injury

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.

h. The Insured Person will 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.

i. Claims Payment

i) We will 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 HDFC ERGO Health 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 You under this Policy. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).The assignment of benefits of the policy shall be subject to applicable law.

iii) Our liability to make payment under this policy will only begin when the Deductible as mentioned in Schedule is exceeded. We will pay to the Insured Person, Medical Expenses over and above Deductible but not exceeding the Sum Insured for the Policy Period. Any claim under this Policy shall be payable by Us only if the aggregate of covered Medical Expenses in respect to Hospitalisation(s) of Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Deductible and all limits of reimbursement under any other Health Insurance policy available to the insured person/s have been exhausted.

iv) Claim payable under this Policy will be the amount by which the aggregate of covered Medical Expenses in respect of hospitalizations with dates of admission falling within the policy period exceeds the Deductible amount mentioned in the schedule.

v) We are not obliged to make payment for any claim or that part of any claim 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.

vi) In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available Sum Insured and applicable deductible in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.

j. 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 without refunding the premium amount; and

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;

i. Permanently exclude the disease/condition and continue with the Policy

ii. Incorporate additional waiting period of not exceeding 3 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

iii. 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 j i above.

k. 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.

l. Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

m. 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

ii) Us,shall be delivered to Our address specified in the Schedule.

iii) No insurance agents, brokers, other person or entity is authorised to receive any notice on Our behalf unless explicitly stated in writing by Us.

n. 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.

o. Waiver of Deductible

We will offer the Insured Person an option to waive the Deductible and to opt for any indemnity health insurance Policy (without any Deductible) offered by Us for same Sum Insured without re-evaluation of health status or any pre policy check provided that:

i. Insured Person has been insured with Us for first time under this Policy before the age of 50 years and has renewed with Us continuously and without any interruption,

ii. This option for waiver of Deductible shall be exercised by the Insured Person during the age group of 55 to 60 years, and certainly at the time of renewal only.

Or

At the beginning of 6th policy yeari.e ; provided that it has been renewed with Us continuously and without any interruption.

iii. Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy.

iv. Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of insured member at renewal.

In all cases, No benefits shall accrue to any Insured Person by virtue of continuity of coverage in the event of discontinuation of this Policy at any point of time or shifting to any other health insurance Policy with Us.

SECTION E. OTHER TERMS & CONDITIONS

I. Special terms and conditions

Deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for eligible medical expenses upto a specified rupee amount as opted and mentioned in the Policy Schedule i.e. it is the amount upto which the insurance company will not pay for all the claims incurred in a Policy Year under the policy

- The Deductible will apply on Individual basis in case of Individual Policy and on family floater basis in case of FamilyFloater Policy.
- A Deductible does not reduce the Sum Insured.

For the purpose of calculation of claim amount we will consider eligible Medical Expenses incurred less the Deductible amount..

II. Claim Related Information

	Within India	Outside India
Claim Intimation:	Customer Service No. 022-62346234 / 0120-62346234 Email: healthclaims@hdfcergo.com Reimbursement Claim Intimation: Visit www.hdfcergo.com - > Help - > Claim Registration	Global Contact No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Emailtravelclaims@hdfcergo.com
Claim document	HDFC ERGO General Insurance Co.	HDFC ERGO General Insurance Co

submission at address:	Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360	Ltd 6th Floor, Leela Business Park, AndheriKurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

ANNEXURE A

Ombudsman Details

The contact details of the Insurance Ombudsman offices are as below-

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD **Office of the Insurance Ombudsman,** Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU **Office of the Insurance Ombudsman,** Jeevan Soudha Building, 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@cioins.co.in	Karnataka.
BHOPAL **Office of the Insurance Ombudsman,** 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR **Office of the Insurance Ombudsman,** 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH **Office Of The Insurance Ombudsman,**	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh,

Office Details	Jurisdiction of Office Union Territory, District)
Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI **Office of the Insurance Ombudsman,** Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
DELHI **Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI **Office of the Insurance Ombudsman,** Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD **Office of the Insurance Ombudsman,** 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR **Office of the Insurance Ombudsman,** Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI **Office of the Insurance Ombudsman,**	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

Office Details	Jurisdiction of Office Union Territory, District)
10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	
KOLKATA **Office of the Insurance Ombudsman,** Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW **Office of the Insurance Ombudsman,** 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, 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 **Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA **Office of the Insurance Ombudsman,** Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA **Office of the Insurance Ombudsman,** 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.

Office Details	Jurisdiction of Office Union Territory, District)
PUNE **Office of the Insurance Ombudsman,** Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE **Office of the Insurance Ombudsman,** 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

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

Endorsements – Optima Super

a) 30 days waiting period

The 30 days waiting period under Section C-1.i) stands deleted for all the Insured Persons.

b) 24 months waiting period for specified Illnesses/ surgeries

i) The 24 months waiting period for the specified Illnesses/ Surgeries specified under Section C-1.ii) stands deleted for all the Insured Persons.

ii) The 24 months waiting period for the specified Illnesses/ Surgeries specified under Section C-1.ii)stands reduced to 12 months for all the Insured Persons.

c) 36 months waiting period for Pre-existing Conditions

i) The 36 months waiting period for the Pre-existing Conditions under Section C-1.iii) stands reduced to 24 months for all the Insured Persons.

ii) The 36 months waiting period for the Pre-existing Conditions under Section C-1.iii) stands reduced to 12months for all the Insured Persons.

iii) The 36 months waiting period for the Pre-existing Conditions under Section C-1.iii) stands deleted for all the Insured Persons.