HDFC ERGO General Insurance

HDFC ERGO Group Protect

Policy Wording

Contents

HDFC ERGO General Insurance

Operating Clause

We will provide Insurance coverage to the **Insured Person**(s) under this **Policy** up to **Sum Insured** including Restore benefit,**Cumulative Bonus** as applicable and subject to waiting periods, limits, Sub-limits, **Co-payment**, **Aggregate Deductible** as specified in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.The **Policy** is based on statements, disclosures, declarations made in the Proposal form / Enrollment form and Medical reports.

Certain words used in the Coverage description have specific meanings which are mentioned in Definitions and which impacts the Coverage. All such words, are mentioned in **Bold** to enable **You** to identify that the particular word has a specific meaning for which **You** need to refer Section – A, Definitions.

A. Definitions

1. Definitions applicable to the Policy

I. Standard Definitions

Def. 1. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. **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 Go*vernment /Central Co*uncil 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. 3. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center 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. 4. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions,

are directly made to the **Network Provider** by the insurer to the extent pre-authorization is approved.

Def. 5. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon

Def. 6. **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal **Congenital Anomaly**: **Congenital Anomaly** which is not in the visible and accessible parts of the body.

b) External **Congenital Anomaly**: **Congenital Anomaly** which is in the visible and accessible parts of the body

Def. 7. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A **Co-Payment** does not reduce the Sum Insured

Def. 8. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 9. **Day care Centre** means any institution established for **Day Care Treatment** of **Illness** and / or injuries or a medical set -up with 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 criterion as under:-

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 10. **Day Care Treatment/ Procedures**means those medicaltreatment, and/or surgical procedure which is

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 **Hospitalization** of more than 24 hours,

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

Def. 11. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of **Hospital** cash policies, which will apply before any benefits are payable by the insurer. A **Deductible** does not reduce the sum insured.

Def. 12. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 13. **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. 14. **Domiciliary Hospitalization** means medical treatment for an **Illness**/disease/**Injury** whichin the normal course would require care and treatment at a **Hospital** but is actually takenwhile confined at home under any of the following circumstances:

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

Def. 15. **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. 16. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.

Def. 17. **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. 18. **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. 19. **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 on-going or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs on-going or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Def. 20. **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. 21. **In-patient Care** means tre**atment for whi**ch the Insured Person has to stay in a **Hospital** for more than 24 hours for a covered event.

Def. 22. **Intensive Care Unit** means an identified section, ward or wing of a **Hospital** which is under the constant supervision of a ded**icated Medical** Practitioner(s), and which is specially equipped for the contin**uous mon**itoring 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. 23. **ICU (Intensive Care Unit) Charges** means the amount charged by a **Hospital** towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 24. **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. 25. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 26. **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 Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 27. **Medically Necessary treatment** 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. 28. **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. 29. **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. 30. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 31. **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. 32. **Non Network**means any **Hospital**, **Day Care Centre** or other provider that is not part of the Network

Def. 33. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 34. **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. 35. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def. 36. **Pre-existing disease** means any condition, ailment, injury or disease:

i. 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 or
ii. 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 or its reinstatement.

Def. 37. **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 Insu**red Person's Hospitalization was requ**ired, **and**

ii. **The In-patie**nt **Hospitalization** claim for such **Hospitalization** is admis**sible by the In**surance Company

Def. 38. **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. 39. **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. 40. **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. 41. **Room Rent** means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the **AssociatedMedical Expenses**

Def. 42. **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. 43. **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. 44. **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.

II. 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 Policy Commencement Date.

Def. 3. **Alternative treatment** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

Def. 4. **Aggregate Deductible:** Aggregate deductible means a cost-sharing requirement that provides that the Company will not be liable for a specified amount of the covered expenses in respect of all admissible claims made under the Policy in aggregate, and which will apply before any benefits are payable by the Company. The Aggregate Deductible does not reduce the Sum Insured.

Def. 5. **Associated Medical Expenses** means consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anaesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def. 6. **Bank rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 7. **Base Sum Insured** means the sum shown in the Policy Schedule which represents **Our** maximum liability for respective section during the Policy Year.

Def. 8. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

Def. 9. **Biological attack** or **weapons** the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 10. **Catastrophic Event** means and includes Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood, Inundation and Earthquake

Def. 11. **Chemical attack** or **weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 12. **Commencement Date** means the commencement date of the Policy as specified in the **Policy Schedule**/Certificate of Insurance

Def. 13. **Coma/Comatose State** means a state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
iv. The condition has to be confirmed by a specialist medical practitioner.
v. Coma resulting directly from alcohol or drug abuse is excluded.

Def. 14. **Coverage Period** means the Period between the Coverage effective date and the expiry date applicable to Insured Person specified in the **Policy Schedule**/Certificate of Insurance.

Def. 15. **EMI or EMI amount** means and includes the amount of monthly payment required to repay the principal amount of loan/credit and Interest by the Insured as set forth in the amortization chart referred to in the agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured Person prior to the date of occurrence of the Insured coverage under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured. EMI refers to the EMI or Pre EMI on the loan/credit or the Sum Insured, whichever is lower, on the date of the Insured Event

Def. 16. **Dependent child/children** means Your children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households.

Def. 17. **Family Floater** means a Policy described **as suc**h in the Policy Schedule where under **You** and **Your** Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date on floater Sum Insured basis.

Def. 18. **Life threatening situation** shall mean a serious medical condition or symptom resulting from **Injury** or **Illness** which is not **pre-existing disease**, which arises suddenly and unexpectedly, and requires immediate care and treatment by a **Medical Practitioner**, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

Def. 19. **Insured Person** means **You** and the persons named in the Policy Schedule who are insured under the Policy.

Def. 20. **Material Facts** means 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. 21. **Medical Consultation** is a procedure where a **Medical Practitioner** reviews an Insured Person's medical history, medically examines the Insured Person and makes recommendations as to care and treatment.

Def. 22. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence;

Def. 23. **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental **Illness**, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental **Illness** are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general **Hospital** or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental **Illness** resides with his relatives or friends;

Def. 24. **Mental Health Nurse** means a person with a diploma or degree in general nursing or diploma or degree in psychiatric nursing recognised by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State

Def. 25. **Non-Medical Expenses – a**re expenses other than those defined as Medical Expenses and which arelisted on our website www.hdfcergo.com

Def. 26. **Nuclear attack** means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

Def. 27. **Period of Insurance** means the period between the Coverage Commencement Date and th**e Expiry** Date specified in the **Policy Schedule**/Certificate of Insurance under the **Policy** with the **Company** under which **Insured Person** is covered.

Def. 28. **Policy** means **Your** statements in the propo**sal form (which are** the basis of this Policy), this policy wording (including endorsements, if any), and the Polic**y Schedule (as** the same may be amended from time to **time)**.

Def. 29. **Policy Period m**eans the peri**od between the** Commencement Date and the Expiry Date specified in the Policy Schedule. For **Insured Person** it means **Period of Insurance** as specified in the Certificate of Insurance or Endorsement

Def. 30. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 31. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to (Schedule of coverage), including any Annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 32. **Policy Year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of

the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

Def. 33. **Preventive Health Check-up** -Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Def. 34. **Second Medical Opinion** means a procedure where by upon request of Insured Person, an independent Medical Practitioner reviews and opines on treating Medical Practitioner's recommendation as to care and treatment of Insured Person by reviewing Insured Person's medical status and history

Def. 35. **Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.

Def. 36. **Sum Insured** means the aggregate limit of indemnity consisting of the Base Sum Insured, Cumulative Bonus, Restore Benefit (provided that these optional covers are in force for the Insured Person) as specified in the Schedule of Coverage on the Policy Schedule/Certificate, for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year

Def. 37. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

Def. 38. **Time Deductible** means a cost sharing requirement under a health insurance **Policy** that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer. A **Time Deductible** does not reduce the **Sum Insured**

Def. 39. **We/Our/Us/Insurer/Company** means the HDFC ERGO General Insurance Company Limited

Def. 40. **You/Your** means the Insured Person named in the Policy Schedule who is insured under the Policy

2. Critical Illnesses – Standard Definitions, applicable to optional cover 'd' under Section B.II

1. Cancer of specified severity

A malignant tumour 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 leukaemia, lymphoma and sarcoma.
The following are excluded:

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

2. 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

3. 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:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
b. New characteristic electrocardiogram changes
c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

a. Other acute Coronary Syndromes
b. Any type of angina pectoris
c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. Kidney failure requiring regular dialysis

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

5. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

a. One of the following human organs: lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ,
b. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

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

6. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
b. 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.

7. Permanent Paralysis of Limbs

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

8. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

   a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.
   b. 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:
   a. Transient ischemic attacks (TIA)
   b. Traumatic injury of the brain
   c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

B. Coverages

All coverage sections in this product are modular in nature and can be opted on a standalone basis or in any possible combination by the policy holder.

I. Hospitalization Expenses

We will pay for the below listed Covers upto the limit as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurance on **Medically Necessary Hospitalization** of an **Insured Person** due to **Illness** or **Injury** sustained or contracted during the **Period of Insurance** subject to terms and conditions as listed below.

For sections B. I and B.II. the liability of the Company to pay the admissible Claim under that Policy Year will commence only once Aggregate Deductible amount as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurancehas been exhausted. This condition shall not apply for Second Opinion in respect of CI, Preventive Health Check-Up and Air Ambulance Cover.

a. In Patient Treatment

We will indemnify the below medical expenses incurred on Inpatient care hospitalization for the insured person following an Illness or Injury that occurs during the Policy Period.

i. **Room Rent** and boarding charges as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurance
ii. **Intensive Care Unit** charges as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurance
iii. Consultation fees & Nursing charges
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
v. Medicines, drugs and consumables
vi. Diagnostic procedures related to admissible hospitalization claim
vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

Proportionate Deduction

In case **Room Rent** during **Hospitalization** of **Insured Person** exceeds the aforesaid limits as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurance, the reimbursement/payment of **Room Rent** charges including all **Associated Medical Expenses** incurred at **Hospital** shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of **Room Rent** charges. This condition is not applicable in respect of **Hospitals** where differential billing for **Associated Medical Expenses** is not followed based on Room Rent.

b. Pre-Hospitalization Expenses

We will pay for the **Pre-Hospitalization Medical Expenses** incurred during the number of daysas specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insuranceimmediately before **Hospitalization** of an **Insured Person.**

Conditions :

- **This benefit will trigger only if we have accepted a claim under Section B. I. a.**
- We shall not pay Pre-Hospitalization expenses incurred prior to inception of the Policy with Us.

c. Post-Hospitalization Expenses

We will pay for the **Post-Hospitalization Medical Expenses** incurred upto the number of days as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurance from the date **Insured Person** is discharged from **Hospital.** In case the benefit based option is opted for this benefit then 1.5% of claim amount for medical expenses paid under this policy on account of hospitalization shall be paid as lumpsum

Conditions:

- This benefit will trigger only if we have accepted a claim under Section B. I. a.

d. Domiciliary Hospitalization

We will pay the **Medical Expenses** as specifiedin the Schedule of Coverageon the **Policy Schedule**/Certificate of Insurance incurred on **Domiciliary Hospitalization** of the **Insured Person** presecribed by treating **Medical Practitioner.**

e. Organ Donor Expenses

We will pay **Medical Expenses** covered under Section B.I.a towards organ donor's **Hospitalization** for harvesting of the donated organ where an **Insured Person** is the recipient subject to condition that;

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/or Regulations.
ii. **Hospitalization** Claim under Section B. I. is admissible under the coverage for the **Insured Person**
iii. The Organ Donor's **Pre-Hospitalization** and **Post-Hospitalization Medical Expenses** are excluded under the **Policy**.
iv. Any other **Medical Expenses** or **Hospitalization** consequent to the harvesting is excluded under the Coverage.

f. Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment following an Illness or Injury that occurs during the Policy Period.

- All day care procedures are covered under this benefit.

g. Road Ambulance Cover

For each admissible Claim under Section B.I.a and B.I.f, **We** will pay upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance per **Hospitalization** for expenses incurred on Road Ambulance Services if **Insured Person** is required;

i. to be transferred to the nearest **Hospital** following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)
ii. or from one **Hospital** to another **Hospital**
iii. or from **Hospital** to Home (within same City) following **Hospitalization**

II. Optional Covers under Section B. I. - Hospitalization Expenses

Insuring Clause

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that **We** will pay/restrict the Medical Expenses and/or waiting periods under below listed Covers subject to waiting periods and limits as specified in the Schedule of Coverage on the **PolicySchedule**/Certificate of Insurance.

Subject to otherwise all other terms, conditions, exclusions and waiting periods applicable to the **Policy**.

These Covers are optional and applicable only if opted for and upto the **Sum Insured** or limits mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.

To opt for any of the below optional covers it is mandatory to opt for Section B.I.

a. Alternative Treatment

i. We will pay Medical Expenses covered under Section B.I.a, on Medically Necessary Hospitalization of Insured Person in AYUSH Hospital upto the limit mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance for following Alternative Treatments prescribed by Medical Practitioner:
    i. Ayurvedic
    ii. Unani
    iii. Siddha
    iv. Homeopathy

ii. For this benefit Exclusion mentioned in Section C.III.xviii will be superceded.

b. Preventive Health Check-Up

i. We will indemnify the Insured Person towards the cost of Preventive Health Check – Up, up to the limit mentioned on the Schedule of Coverage in the Policy Schedule/Certifiate of Insurance.

ii. Other terms and Conditions applicable to this Coverage

a) The Coverage will be applicable as per the eligibility as mentioned on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance.
b) In case of Annual Eligibility, the percentage and limit will be calculated on expiring Coverage **Sum Insured** and will be only applicable to **Insured Person** covered under expiring Coverage, irrespective of claims under Base Coverage.

c) In case of Eligibility at the end of each block of continuous three claim free years, the percentage and limit will be calculated on Average **Sum Insured** during block of three years and will be only applicable to **Insured Person** covered for all previous 3 years.
d) Claim under this Cover does not impact the **Sum Insured** or the eligibility for **Cumulative Bonus.**
e) The test reports received under this Coverage will not be utilized for re-underwriting the expiring coverage of I**nsured Person**
f) In case of Individual policies this benefit would be on per member basis
g) In case of Floater policies this benefit would be at policy level

c. Co-Payment

On availing this option, **Co-Payment** as mentioned in the Schedule of Coverage on the **PolicySchedule**/Certificate of Insurance will be applied on each and every admissible claim under Section B. I. , B. II. a. Alternative Treatment (if opted) and B. II. h. Air Ambulance Cover (if opted)

d. Second Opinion in respect for Critical Illness (CI)

i. **We** will pay expenses incurred towards **Second Medical Opinion** availed from **Medical Practitioner**in respect of **Critical Illnesses (CI)** listed below through our **Network Provider**.

ii. The coverage under this benefit shall be available as per the below conditions:

- One **Second Medical Opinion**from the below listed **Critical Illness** per **Insured Person** per **Policy Year** shall be availablefor both individual and floater policies.

CriticalIllnesses Covered			
1	Cancer of specified severity	5	Major Organ/Bone Marrow Transplant
2	Open Chest CABG	6	Multiple Sclerosis with Persisting Symptoms
3	Myocardial Infarction(First Heart Attack of specific severity)	7	Permanent Paralysis of Limbs
4	Kidney Failure requiring regular dialysis	8	Stroke resulting in Permanent Symptoms

Disclaimer –*Second Medical Opinion Services are being offered by Network providers through its portal/mail/App or what so ever electronic form to Policyholders/Insured of HDFC ERGO GENERAL INSURANCE LIMITED. In no event shall HDFC ERGO be liable for any direct, indirect, punitive, incidental, special consequential damages or any other damages whatsoever caused to the Policyholders/Insured of HDFC ERGO while receiving the services from Network providers.*

e. Restore Benefit

In the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year irrespective of the utilization of the Cumulative Bonus, the Company shall restore the Sum Insured up to the Base Sum Insured (as applicable under the current Policy Year) for any subsequent claims admissible under Section B.I & Alternative treatment benefit (if opted), subject to the following conditions:

i. This Benefit shall be applied for the number of times as mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.

ii. The Base Sum Insured restoration under the Restore Benefit would be triggered only upon complete or partial utilization of the Base Sum Insured, or complete or partial utilization of Restore benefit as may be applicable by the way of claims admitted under the Policy.Restore benefit shall be available for subsequent claims thereafter in the Policy Year, for the Insured Person.

iii. In case of a family floater policy, the Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

iv. Single claim in a Policy Year cannot exceed the Base Sum Insured and Cumulative Bonus (if applicable).

Illustration :

Base Sum Insured : 5 Lacs

Cumulative Bonus : 2.5 Lacs

Number of Claim	**Claim amount**	**Available Benefit Limit**				**Admissible claim amount**	**Utilization of Sum Insured**
		Base SI	**Cumulative Bonus***	**Restore Benefit**	**Unlimited Restore Benefit**		
1st claim	7,00,000	5,00,000	2,50,000	0	0	7,00,000	Base SI + Cumulative Bonus (Partial)
2nd claim	3,50,000	-	50,000	5,00,000	0	3,50,000	Cumulative Bonus (balance) + Restore (partial)
3rd claim	3,00,000	-	-	2,00,000	5,00,000	3,00,000	Restore (balance) + Unlimited Restore
4th claim	7,00,000	-	-	-	5,00,000	5,00,000	Unlimited Restore
5th claim	5,00,000	-	-	-	5,00,000	5,00,000	Unlimited Restore

*if opted

f. Cumulative Bonus

i. On each continuous completion of a Policy Year of the Coverage with **Us**, **We** will apply percentage of Base **Sum Insured** as specified in the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance under expiring policy year as **Cumulative Bonus** in the Coverage provided that;

a) There has been no claim under the Coverage in expiring Policy Year.

b) **Cumulative Bonus** will be reduced at the same rate as accrued in the event of admissible Claim under the Coverage.

c) **Cumulative Bonus** can be accumulated upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

d) **Cumulative Bonus** applied will be applicable only to **Insured Person(s)** covered under the expiring policy year and who continue to remain insured on **Renewal**.

g. Recovery Benefit

We will pay a lump sum amount of INR 2000 for Hospitalization of an Insured Person exceeding 5 consecutive and continuous days and for which Claim is paid under Section B. I. – Hospitalization Expenses or Alternative treatment benefit (if opted). This benefit is payable only once in a policy year and the lump sum amount payable shall be over and above Sum Insured. This benefit is not applicable if Medical Treatment is taken under Section B. I. d. Domiciliary Hospitalization.

h. Air Ambulance Cover

We will pay for Air Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid ambulance transportation as prescribed by a Medical Practitioner, from the site of first occurrence of the Illness/ Accident to the nearest Hospital, that ground transportation cannot provide. Claim would be reimbursed as per limits specified in the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance. Under this benefit, we shall not pay for return transportation to the Insured Person's home by air ambulance. This benefit is payable over and above Sum Insured.

i. Pre-Existing Disease Waiting period Modification Option

i. On availing this option, Waiting Periods listed under Section C. I.i shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered.

j. Specified Disease/Procedure (Specific Illness) Waiting period Modification Option

i. On availing this option, Waiting Periods listed under Section C. I.ii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered.

k. General Waiting Period (30-day waiting period) Modification Option

i. On availing this option, Waiting Periods listed under Section C. I.iii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered

l. Pre and Post Hospitalisation Expenses Days Modification Option

i. On availing this option, Pre and Post Hospitalization Medical Expenses limits specified under Section B.I.b and B.I.c respectively shall stand modified for either or both of the respective benefits as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered.

m. Room Rent Restriction

On availing this option, Room Rent and ICU limitsunder Section B.I.a shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

n. Road Ambulance Cover Modification Option

On availing this option, Road Ambulance limit specified under Section B.I.g shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

III. EMI Hospitalization

We will pay the Lumpsum amount on completion of defined number of days of Hospitalizationas stipulated in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance if an Insured Person is hospitalized due to illness or injury.

Conditions applicable to **EMI Hospitalization** benefit

a. The maximum worth of claim payout in a Policy Year shall not exceed the number of times/amount as mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance of Lumpsum Sum Insured chosen.

b. Fraction of Lumpsum Sum Insured chosen to be paid every time claim triggers shall be as specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance

c. Exclusions & waiting periods applicable to this benefit by default shall be as per Section C. and in case modification option is exercised the Exclusions & waiting periods applicable shall be as specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance

d. Coverage for this section shall be on individual basis in case more than one member is part of the policy

IV. Optional Covers under Section B. III. - EMI Hospitalization

To opt for any of the below optional covers it is mandatory to opt for Section B. III.

a. Maternity coverage

If Maternity coverage option is chosen by the Insured then the maternity exclusion as mentioned in Section C. II. xv shall stand deleted & Waiting period for maternity as per Section C.I.iv shall apply and the same shall be as mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

b. Cumulative Bonus for EMI Hospitalization benefit

i. On each continuous completion of a Policy Year of the Coverage with **Us**, **We** will apply **Cumulative Bonus** in the coverage in conjunction with conditions specified below

a) There has been no claim under the Coverage in expiring Policy Year.
b) **Cumulative Bonus** shall be accumulated at 10% of Base Sum Insured every claim free year and maximum accumulation shall be upto 50% of Base Sum Insured
c) **Cumulative Bonus** will be reduced at the same rate as accrued in the event of admissible Claim under the Coverage.
d) **Cumulative Bonus** applied will be applicable only to **Insured Person(s)** covered under the expiring policy year and who continue to remain insured on **Renewal**.

c. Pre-Existing Disease Waiting period Modification Option

i. On availing this option, Waiting Periods listed under Section C. I.i shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered.

d. Specified Disease/Procedure (Specific Illness) Waiting period Modification Option

i. On availing this option, Waiting Periods listed under Section C. I.ii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered.

e. General Waiting Period (30-day waiting period) Modification Option

i. On availing this option, Waiting Periods listed under Section C. I.iii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. All other terms and Conditions of the Policy shall remain unaltered

V. Wellness Services

All the below benefits are a bundled offering and must be chosen in its entirety. The below benefits would be serviced by our empanelled ServiceProvider on per Insured Person per Policy Year basis.

Note for all Insured persons :

i. Consultation must not be considered a substitute to medical opinion or advise nor shall the same be pursued over a medical advice or opinion given by treating Medical Practitioner

ii. By seeking Tele/Video/Physical consultation under this benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
iii. The Insured Person is free to choose whether or not to obtain the Tele/Video/Physical consultation, and if obtained then whether or not to act on it in whole or in part.
iv. Consultations/benefit programs can be booked digitally & any unutillised consultations shall lapse & will not be carried forward. Information regarding limits for all the below benefits shall be available on the digital platform of our empanelled Service Provider.
v. Tele/Video/Physical consultation under this benefit shall not be valid for any medico-legal purposes.
vi. We do not represent correctness of Consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner

a. Anytime Doc-on-Call

i. We will cover Tele Consultations (without prescriptions) with certified Medical Practitioners for the Insured.
ii. A Tele consultation is an out-patient consultation, which is conducted over an audio call between the Insured and the Medical Practitioner.

b. Doctor Consultations

i. We shall provide discounts on consultations with certified Medical Practitioners for the Insured from our empanelled Service Provider.
ii. The cost of consultations shall be borne by the Insured Person.

c. Diagnostic Tests

i. We shall provide discounts on diagnostic tests availed by the Insured person, from our empanelled Service Provider.
ii. The cost of diagnostic tests shall be borne by the Insured Person.

d. Base Diabetes Management Program

We shall provide access to Diabetes Management Program for the Insured from our empanelled Service Provider.

e. Tele / Video Consultations

We shall provide discounts on Tele/Video Consultations with certified Medical Practitioners for the Insured through our empanelled Service Provider.

f. Concierge for 24|7 Services

As part of the 24x7 Concierge services we shall provide digital Booking assistance.

g. Nutritionist Consultation & Diet Planning

We shall provide Nutritionist Consultation & Diet Planning for the Insured from our empanelled Service Provider.

C. Exclusions and Waiting Periods

We will not make 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 the **Policy**

The below mentioned standard waiting periods apply to benefits chosen under Section B I,II, III, IV

Choice of Waiting period for benefits under Section B. I & II and Section B. III & IV can be different and the same shall be specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance

I. Standard Waiting Periods

Claims under the Policy are covered subject to Waiting Period as specified below:

i) **Pre-existing Diseases waiting period – 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 number of months of continuous coverage as specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance after the date of inception of the 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 number of months of continuous coverage as specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insuranceafter the date of inception of the policy with insurer for any **pre-existing disease** is subject to the same being declared at the time of application and accepted by Insurer.

ii) **Specified Disease/Procedure (Specific Illness) waiting period- Code – Excl02**

a) Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of number of months of continuous coverage as specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insuranceafter 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.

Illnesses

Internal Congenital diseases	Non infective Arthritis	Pilonidal sinus
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g.Kidneystone,Urinary Bladder Stone	Benign tumors, cysts, nodules, polyps including breast lumps
Pancreatitis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors

Cataract	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Osteoarthritis and osteoporosis	Fibroids (fibromyoma)	Benign Hyperplasia of Prostate

Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy	Hernia
Dilatation and curettage (D&C)	Nasal concha resection	Surgery for prolapsed inter vertebral disc
Myomectomy for fibroids	Surgery of Genito urinary system	Surgery for varicose veins and varicose ulcers
Surgery on prostate	Cholecystectomy	Surgery for Perianal Abscesses
Hydrocele/Rectocele	Joint replacement surgeries	Surgery for Nasal septum deviation
Ligament, Tendon and Meniscal tear	Prolapsed Uterus	Rectal Prolapse
Endometriosis	Retinal detachment	Glaucoma
Varicocele	Hysterectomy	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries
Nasal polypectomy		

iii) **General Waiting Period (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.

iv) **Maternity waiting period (Only applicable to Section B. IV. a. and if maternity optional coverage is opted)**

A waiting period of number of yearsas specified in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insuranceafter the date of inception of the **Policy** with us shall apply for all Maternity related claims under section B. IV. a.

II. Standard Permanent 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)
      a. Greater than or equal to 40 or,
      b. 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. **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-** 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.

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. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Code – Excl15

xiii. **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

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.

III. Specific Permanent 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 **Biological** attack or weapons, radiation of any kind.

ii. Aggregate Deductible - We are not liable for Claims/Claim amount falling within **Aggregate Deductible** limit if applicable and as mentioned on the Schedule of Coverage in the **PolicySchedule**/Certificate of Insurance.

iii. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide.

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

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

vi. Congenital external diseases, defects or anomalies,

vii. Stem cell harvesting.

viii. Investigative treatments for analysis and adjustments of spinal sub luxation, 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).

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

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

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

xii. **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.hdfcergo.com.

xiii. OPD treatment,

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

xv. 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.

xvi. 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.

xvii. 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 is attached and also available on www.hdfcergo.com

xviii. Non- allopathic treatments

D. General Conditions

I. Standard General Conditions

1. 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**.

2. Condition Precedent to Admission of Liability
   The terms and conditions of the **Policy** must be fulfilled by the **Insured Person** for the **Company** to make any payment for claim(s) arising under the **Policy**.

3. 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.

4. Multiple Policies
   i. In case of multiple policies taken by an **InsuredPerson** during a period from one or more insurers to indemnify treatment costs, the **InsuredPerson** 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 **InsuredPerson**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**.

5. 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.

6. 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**.

7. 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.

8. Migration

The **Insured Person** will have the option to migrate the **Policy** to other health insurance products/plans offered by the **Company**by applying for **Migration** of the **Policy** atleast 30 days before the **Policy** renewal date as per IRDAI guidelines on **Migration**. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the **Company**, the **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Migration**.

For Detailed Guidelines on Migration, kindly refer the link

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

9. Portability

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the **Policy** renewal date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health

insurance **Policy** with an Indian General/Health insurer, the proposed **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Portability**.

For Detailed Guidelines on Portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. Cancellation

I. The **Policyholder** may cancel this **Policy** by giving 15days' written notice and in such an event, the **Company** shall refund premium for the unexpired **Policy Period** as detailed below.

For Policies where instalment option is not availed, We will refund premium in accordance with the table below:

Month/Policy Tenure	1 year	2 year	3 year	4 year	5 year
	% Return Premium				
Upto1	90%	95%	95%	95%	95%
>1 - 3	70%	85%	85%	90%	90 %
>3 - 6	45%	75%	80%	85%	85%
>6 - 12	0%	50%	60%	70%	75%
>12- 15	NA	35 %	50 %	60 %	70 %
>15 - 18	NA	20%	45%	55%	65%
>18 - 24	NA	0%	30%	45%	55%
>24 - 27	NA	NA	20%	35%	45%
>27 - 30	NA	NA	10%	30%	40%
>30 -36	NA	NA	0%	20%	35%
>36 - 39	NA	NA	NA	10%	25%
>39 - 42	NA	NA	NA	5%	20%
>42 - 48	NA	NA	NA	0%	15%
>48 - 51	NA	NA	NA	NA	10%
>51 - 54	NA	NA	NA	NA	5%
>54 - 60	NA	NA	NA	NA	0%

For Policies where Premium is paid by instalment, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the **PolicyYear**. For instalment after 6 months, no refund will be payable.

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 **MaterialFacts** or **Fraud**.

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 period in case of death of any **Insured Person/s**

11. Premium Payment in Instalments

If the **Insured Person** has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the **Policy Schedule**/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the **Policy**)

i. **Grace Period** as mentioned in the table below would be given to pay the instalment premium due for the **Policy.**

Options	Installment Premium Option	Grace Period applicable
Option 1	Half Yearly	30 days
Option 2	Quarterly	30 days
Option 3	Monthly	15 days

ii. During such **Grace Period**, coverage will not be available from the due date of instalment premium till the date of receipt of premium by **Company**.

iii. The **Insured Person** will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated **Grace Period**.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the **Grace Period**, the **Policy** will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The **Company** has the right to recover and deduct all the pending installments from the claim amount due under the **Policy**.

12. Instalment premium payment through Auto Debit/ECS Facility

i. If Option of Premium payment by instalment is opted through auto Debit/ECS facility, Electronic Clearing Service (ECS) Mandate form needs to be completely filled & signed by the Insured Person.

ii. The Premium amount which would be auto debited & frequency of instalment should be duly filled in the ECS Mandate form.

iii. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.

iv. The Company should beinformed at least 15 days prior to the due date of instalment premium if the Insured Person wishes to discontinue the ECS facility.

v. Non-payment of premium on due date as opted by the Insured Person in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

13. 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.

14. 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.

15. 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 **PolicySchedule**/**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**.

16. Claim Settlement (provision for Penal Interest)

i. 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.

ii. 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**.

iii. 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.

iv. 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.

17. Renewal of Policy:

The **Company** shall be under no obligation to renew the **Policy**/Coverage on expiry of the period for which premium has been paid. The **Company** reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This **Policy** may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The **Company**, however, shall not be bound to give notice that the **Policy** is due for **Renewal** or to accept any **Renewal** premium. Unless renewed as herein provided, this **Policy** shall automatically terminate at the expiry of the **Policy Period/ Coverage Period.**

18. Redressal of Grievance

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

- Website: www.hdfcergo.com
- Toll free: 022 6234 6234 / 0120 6234 6234
- Contact Details for Senior Citizen: 022 – 6242 – 6226 | seniorcitizen@hdfcergo.com
- E-mail: grievance@hdfcergo.com

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 cgo@hdfcergo.com

For updated details of grievance officer, kindly refer the link:
https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6234 6234 / 0120	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6234 6234 / 0120

		6234 6234	6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

i. 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.

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

III. Specific General Conditions

1. 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 **Policy Schedule**/Certificate of Insurance, 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;

a) Permanently exclude the disease/condition and continue with the **Policy**

b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the **Policy**.

c) Levy underwriting loading from the first year of issuance of **Policy** or renewal, whichever is later.

The above options will not prejudice the rights of the **Company** to invoke cancellation under clause 1 i above.

2. Geography
   This **Policy** only covers Medical Treatment taken within India.

3. Assignment
   Assignment Clause: It is hereby declared and agreed for loan linked customers (wherever applicable) that :
   i. From the Policy Start Date,the monies payable by the Company to the Insured and all rights, title, benefits and interest of the Insured under 'Section B. III & IV EMI Hospitalization' of this Policy stand assigned in favour of the "Bank / Financial institution as named in the Schedule of this Policy.
   ii. Upon any monies becoming payable under this Policy the same shall be paid by the Company to the " Bank / Financial institution as named in Schedule of this Policy " without any reference / notice to the Insured , but not exceeding the Principal Out standing as defined under the Policy . In the event of any monies payable under this Policy exceeding the Principal Out standing , the Company shall pay such monies as exceeding the Principal Outstanding to the Insured/Nominee ;
   iii. The receipt of such monies in the manner aforesaid by the Bank/Financial Institution as named in the Schedule of this Policy and the Insured shall completely discharge the Company from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.
   iv. That any adjustment, settlement, compromise or reference to arbitration in connection with any dispute between the Company and the insured or any of them arising under or in connection with this policy if made by the Financier shall be valid and binding on all parties insured here under but not so as to impair right of the Financier to recover the full amount of any claim it may have on other parties insured here under but not so as to impair.
   v. The benefits under this **Policy** are assignable subject to applicable Laws.

4. Loadings
   i. **We** may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.
   ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each **Insured Person**
   iii. Loadings will be applied from Commencement date of the **Policy** including subsequent **Renewal**(s) with **Us** or on increased **Sum Insured**. We will not apply any additional loading on **Your Policy** premium at **Renewal** based on claim experience in **Your Policy**.
   iv. **We** will inform **You** about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the **Policy** only on **Your** acceptance within 15 days of the receipt 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.

5. Grace Period
   i. A **Grace Period** of 30 days is available for Renewal of the Coverage. Any **Illness**, disease or condition contracted during **Grace Period**will not be covered and will be treated as **Pre-existing diseases**.
   ii. For **Renewal** received after completion of **Grace Period**, the Coverage would be considered as fresh without any **Renewal** benefits
   iii. For Policies on instalment basis, Grace Period is available as given below.

Instalment Premium Option	**Grace Period applicable**
Half Yearly	30 days
Quarterly	30 days

Monthly	15 days

6. Endorsements
The following endorsements are permissible during the **Policy Period**:

Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / **Insured Person** (and not the complete name change)
ii. Rectification in gender of the **Insured Person**
iii. Rectification in relationship of the **Insured Person** with the Proposer
iv. Rectification of date of birth of the **Insured Person** (if this does not impact the premium)
v. Change in the correspondence address of the **Insured Person**/Proposer(if this does not impact the premium)
vi. Change in Nominee Details
vii. Change in Height, weight, marital status (if this does not impact the premium)
viii. Change in bank details
ix. Any other non-financial endorsement

Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth
ii. Change in Height, weight
iii. Addition of **Insured Person** (New Born Baby or newly wedded spouse)
iv. Deletion of **Insured Person** on death or Marital separation
v. Any other financial endorsement

The **Policyholder/Insured Person**shallapply in a proposal form along with birthCertificate / marriage certificate as the case may be for addition of **Insured person**.

7. Communication & Notice
Policy and any communication related to the **Policy** shall be sent to through electronic modes or to the address of the Insured as recorded in the **Policy**.

E. Other Terms & Conditions

I. Claims Procedure

1. Notification of a Claim

Procedure	Cashless Hospitalization		Reimbursement Claims
	Emergencies	Planned	
Claim Intimation **You** shall intimate the Claims to us through any available mode of communication as specified in the **Policy**, Health Card or our Website			

Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for claim notification	1. The health card issued by Us 2. KYC documents 3. The Policy Number 4. Name of the Policyholder 5. Name and address of Insured Person in respect of whom the request is being made 6. Nature of the Illness/Injury and the treatment/Surgery required 7. Name and address of the attending Medical Practitioner 8. Hospital where treatment/Surgery is proposed to be taken or /Hospital where the Insured person is admitted 9. Proposed /Actual Date of admission 10. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.		
Claims documents and procedure for Second Medical Opinion	1. Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) 2. Select **Our** network **Medical Practitioner** from whom you would prefer to take the second opinion. (Please refer our Website or call at 24X 7 toll free line to obtain the list of **Our** panel doctors). 3. On receipt of the complete set of documents, We will forward the same to the concerned doctor. 4. The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.		

Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the **Insured person**(s) iii. Nature of disease/**Illness**/**Injury** iv. Name and address of the attending**Medical Practitioner/Hospital** v. Date of admission & probable date of discharge vi. Approximate Claim Expenses	Not Applicable
	Any other relevant information as required	
Process for pre-authorization	On receipt of duly filled pre authorization form and other details, We may; • Issue the authorization letter specifying the sanctioned amount, limitation, and non-payable items, if applicable Or • Reject the request for pre-authorization specifying reasons for the rejection.	Not Applicable
List of Claim documents	Not Applicable	As enlisted below
Condonation of Delay	If the claim is not notified/ or submitted to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We**will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control	

2. List of documents for Reimbursement Claims

i. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by **Hospital**).
ii. Government approved Photo ID & Age Proof
iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of **Hospitalization** in any non-network hospital of HDFC ERGO General Insurance Limited or certificate from **Hospital** authorities providing facilities available including number of beds.
v. Discharge Card / Day Care Summary / Transfer Summary
vi. Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded
vii. Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
viii. All previous consultation papers indicating history and treatment details for current **Illness** and advice for current hospitalization.
ix. All diagnostic reports (including imaging and laboratory) along with prescription by **Medical Practitioner** and invoice / bill with receipt from diagnostic centre
x. All medicine / pharmacy bills along with prescription by **Medical Practitioner**
xi. MLC / FIR Copy – in **Accidental** cases only

xii. History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.
xiii. Copy of Death Summary and copy of Death Certificate (in death claims only)
xiv. Pre and Post-Operative Imaging reports
xv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).
xvi. Invoice for Vaccination and payment receipt
xvii. KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Claimant carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Claimant ***
xviii. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)
xix. Settlement letter(s), copy (-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of Insured Person, the same document reuqirement would be for nominee/legal heir of Insured Person(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility (Applicable only to Section B I & II & not for B III & IV)

i. **Cashless facility** can be availed only at **Our Network Provider**. The complete list of **Network Providers** and empanelled Service Providers is available on **Our** website and can be obtained by contacting **Us**.
ii. We reserve the right to modify, add or restrict any **Network Provider** for Cashless Facilities at **Our** sole discretion. The same shall be duly updated on **Our** website. **You** shall check the updated list of **Network Providers** before applying for Cashless Claim.
iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the **Hospitalization**/treatment, including dates**, Hospital** and locations match with the details as per Cashless authorized.
iv. **We** will make payment for the Cashless authorized amount directly to the **Network Provider**.
v. If the claim is not notified to **Us** within the specified time limits, then **We** shall be provided the reasons for the delay in writing. **We** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim (Not applicable to Section B.V)

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, **We** will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. 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.
iii. In the case of delay in the payment of a claim, the **Company** shall be liable to pay interest to the **Policyholder/Insured Person** from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.
iv. 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.
v. In case of delay beyond stipulated 45 days, the **Company** shall be liable to pay interest to the **Policyholder/Insured Person** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.
vi. If **We**, for any reason decide to reject the claim, the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.

vii. If requested by **Us,** at **Our** cost, the **Insured Person** must submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and **We/Our** representatives must be permitted to inspect the medical and Hospitalization records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.

viii. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess **Our** liability and quantum in respect of the claim

ix. Claim payment & process for Section B. III & IV EMI Hospitalization

- For Credit Linked Policies: Claim will be paid to Financier. In case EMI coverage taken differs from the EMI amount, following three scenarios can happen:
  1. EMI amount is more than actual EMI – Policy will pay entire amount to financier and residual amount after paying EMI will be adjusted against principle amount.
  2. EMI amount is less than actual EMI – Policy will pay entire amount to financier.
  3. EMI amount is more than actual EMI and loan gets foreclosed with EMI payment– Policy will pay entire amount to financier and residual amount after paying EMI will be paid to the Insured person/nominee as loan has got repaid with the EMI amount.
- For Non Credit Linked Policies – Claims will be paid to Insured person / nominee.

x. In case of Employer – Employee policies, the claims of individual persons insured may be processed through the master policyholder. Further in case of Non employer - employee cases, the master policyholder may facilitate the settlement of the claim to the insured however the insurer is totally responsible to pay claim in the name of the insured person.

II. Contact Us

For any claim related query, intimation of claim and submission of claim related documents, You can contact HDFC ERGO General Insurance Limited through:

Details	**Within India**
Claim intimation	Customer Service No. 022-62346234 / 0120-62346234 E-mail: healthclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh

Ombudsman Details

Office Details	**Jurisdiction of Office Union Territory,District)**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

Email: bimalokpal.ahmedabad@cioins.co.in	
BENGALURU - Smt. Neerja Shah 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 - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar 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@cioins.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@cioins.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

Email: bimalokpal.delhi@cioins.co.in	
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.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 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Smt. Sandhya Baliga 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.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur,

Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad 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 Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, 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@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I –

List I – Items for which coverage is not available in the policy

HDFC ERGO General Insurance

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

List II – Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG