HEALTH WALLET

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

Section. 1. In-patient Benefits

This section of benefits is applicable when

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

IMPORTANT: Claims made under these benefits will impact eligibility for Multiplier Benefit.

	We will cover the Medical Expenses for:	**In addition to the waiting periods (Section 7a) and general exclusions (Section 7c), We will also not cover expenses**
	a. In-patient Treatment. This includes • Hospital room rent or boarding; • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	
	b. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital (In-patient, Day Care or Domiciliary Treatment).	i) Claims which have NOT been admitted under 1 a), 1d), and 1e). ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
	c. Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 90 days after discharge from the Hospital. (In-patient, Day Care or Domiciliary Treatment).	i) Claims which have NOT been admitted under 1 a), 1d), and 1e). ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
	d. Day Care Procedures Medical Expenses under 1a) Inpatient treatment on	i) Out-patient treatment/expenses

Important terms You should know.

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

Out-patient Treatment means the medical consultation, investigations or treatment taken in a clinic / hospital or associated facility like a consultation room. Important to note that out-patient treatment does not require admission to day care or in-patient sections of hospital.

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 licence. And is NOT a member of the Insured Person's family or stays with him.

	Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment	
	e. Domiciliary Treatment Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii. The patient takes treatment at home on account of non availability of room in a Hospital.	1. Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days only if treatment period is greater than three days).
	f. Organ Donor: Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an insured person while donating an organ is not covered.	1. Claims which have NOT been admitted under 1a) for insured member. 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
	g. Ambulance Cover Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have not been admitted under Section 1a) and Section 1d).
	h. AYUSH Treatment Expenses incurred on treatment taken under Ayurveda, Unani, Sidha and Homeopathy in a Ayush hospital. **IMPORTANT**: This benefit is not applicable if optional Deductible is chosen.	1. Claims which have not been admitted under 1a). 2. Treatment availed outside India 3.

	i. Recovery Benefit If the Insured Person was Hospitalised beyond 10 continuous days, a lumpsum amount, as mentioned in Schedule of Benefits, will be payable. **IMPORTANT**: 1. This benefit is payable only once per Illness/Accident per Policy Year. 2. This benefit is not applicable if optional Deductible is chosen	1. Claims which have NOT been admitted under 1a).
	j. Worldwide Emergency Care Expense on treatment of illness or conditions first manifested during the Policy Period while travelling overseas, provided • Hospitalisation or Day Care Procedure was necessary and was done. • The expenses were up to limits specified in the Schedule of benefits. • Condition has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India. **IMPORTANT:** a. For the purpose of this benefit, Hospital means "Any institution established for In-patient treatment and Day Care Treatment of injury or illness and which has been registered as a Hospital or a clinic as per law rules and/or regulation applicable for the country where the treatment is taken. " b. Any payment will only be on reimbursement basis; c. The payment of any claim under this benefit will be based on the rate of exchange as on the date of	

	invoice from the Hospital. The rate published by Reserve Bank of India (RBI) shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where on the date of invoice, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion; d. Our overall liability will be limited to a maximum of Rs.20 lacs; subject to Policy Sum Insured; e. Section 8 b) General Terms and Conditions do not apply to this benefit.	

Section. 2. Restore Benefit

	If the Basic Sum Insured and Multiplier Benefit (if any) is exhausted due to claims made and paid during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Basic Sum Insured) will be automatically available for the particular Policy Year, provided that: a) The Restore Sum Insured will be enforceable only after the Basic Sum Insured inclusive of the Multiplier Bonus under Section 4 have been completely exhausted in that year; and b) The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1; c) The Restore Sum Insured can be used for only future claims made by the Insured Person.	Illness/Disease (including its complication) for which a claim has already been paid to the Insured Person in the current Policy Year under Section 1. **IMPORTANT**: In a Family Floater the Illness or disease will be covered in case a claim is made by any other Insured Person other than the Insured Person who has already claimed for that Illness or disease.

	d) No Multiplier Bonus under Section 4 will apply to the Restore Sum Insured; e) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year; f) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year. Incase Family Floater Policy, Restore Sum Insured will be available for all Insured Persons in the Policy.	

Section. 3. Preventive Health Check-up

At each renewal, We will reimburse expenses incurred on preventive health check-up by an Insured Person upto the amount mentioned in the table below. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

IMPORTANT: This benefit does not carry forward if it is not claimed and would not be provided if Health Wallet Policy is not renewed further.

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.

Reserve Benefit Sum Insured* (Rs)	**Plan**	**5000**	**10000**	**15000**	**20000**	**25000**
For Non Deductible plans	Individual	Not Offered	Upto Rs 1500, per individual	Upto Rs 2500, per individual	Upto Rs 3000, per individual	Upto Rs 3500, per individual
	Family Floater	Not Offered	Upto Rs 3000, per policy	Upto Rs 5000, per policy	Upto Rs 6000, per policy	Upto Rs 7000, per policy
For Deductible plans	Individual	Not Offered	Upto Rs 1000, per individual	Upto Rs 2000 per individual	Upto Rs 2500 per individual	Upto Rs 3000 per individual
	Family Floater	Not Offered	Upto Rs 2000, per policy	Upto Rs 4000, per policy	Upto Rs 5000, per policy	Upto Rs 6000 per policy

*Reserve Benefit has been explained in Section 5 below.

Section. 4. Multiplier Benefit

a) If NO claims have been made in respect of any benefit listed under Section 1 in a Policy Year and the Policy is renewed with Us without any break
   i) We will apply a bonus by enhancing the renewed policy's Sum Insured by 50% of the Basic Sum Insured of the previous year's Policy.
   ii) The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

   In Family Floater policy,

   1. The Multiplier Benefit shall be available on Family Floater basis and accrue only if no claims have been made in respect of any Insured Person during the previous Policy Year.

   2. Accrued Multiplier Benefit is available to all Insured Persons under the Policy.

b) If a Multiplier Benefit has been applied and a claim is made in any Policy Year , then in the subsequent Policy Year We will automatically decrease the accrued Multiplier Benefit at the same rate at which it is accrued . However this reduction will not reduce the Sum Insured below the Basic Sum Insured of the policy, and only the accrued multiplier bonus will be decreased.

c) If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the multiplier bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the multiplier bonus to be carried forward for credit in the Policy would be the lowest accrued multiplier bonus amongst all the Insured Persons from the expiring Policy.

d) Portability benefit will be offered to the extent of sum of previous sum insured and accrued multiplier bonus, portability benefit shall not apply to any other additional increased Sum Insured.

e) This benefit does not apply to Reserve Benefit.

Section. 5. Reserve Benefit

Any claims made under this benefit will not be subject to In-patient Benefit Sum Insured and will not impact eligibility for a Multiplier Benefit. Sum Insured limit will apply on Individual basis in case of individual Sum Insured policy and on Family Floater basis in case of Family Floater Policy. Exclusions mentioned in Section 7.b. will not apply to this benefit.

- We will apply a 6% bonus on the un-utilized Reserve Benefit Sum Insured available at the end of the Policy Year irrespective whether claim is made on the expiring policy. This un-utilized Reserve Benefit Sum Insured plus the bonus amount will be carried forward to the next Policy Year.

- At each renewal the 6% bonus will be applied on the balance Reserve Benefit Sum Insured, irrespective of any change in the Basic Sum Insured or Reserve Benefit Sum Insured opted.

- The Sum Insured shown in the policy schedule will be the maximum amount that can be claimed during any given Policy Year. The available Reserve Benefit in the current Policy Year will be total of un-utilized Reserve Benefit sum insured plus bonus amount and the Reserve Benefit Sum Insured of the current Policy Year.

- Bonus on the Reserve Benefit shall not accrue if the Policy is not renewed with Us within the Grace Period.

- The mentioned bonus percentage would be reviewed annually. Change if any, to the bonus percentage shall be done post seeking prior approval from the Insurance Regulatory and Development Authority of India (IRDAI).

- The claims incurred under Reserve Benefit during a Policy Year if claimed in the subsequent Policy Year(s) would be accounted in the Policy Year in which the claim amount was incurred. In such cases the Reserve Benefit Sum Insured would be suitably adjusted at the time of renewal.

An illustration of the working of the Reserve Benefit
Consider an individual who has chosen a Reserve Benefit Sum Insured of Rs. 5000 at inception of the policy.

Policy Year	(A)	(B)	(C)	(D)	(E)	(F)	(G)
	Reserve Benefit Sum Insured Opted (Rs)	Bonus for previous Year announced on or before March 31st of the next year	Reserve Benefit Sum Insured eligible for bonus for the year (Rs) C = F (previous year) – E +A	Bonus amount (Rs) D=BXC	Amount claimed from Reserve Benefit Sum Insured during the year (Rs)	Reserve Benefit Sum Insured with Bonus amount by end of the year (Rs) F = C +D	Reserve Benefit Sum Insured available for utilization/ withdrawal (Rs) G = F +A
Year 1	5000	6%	5000	300	NA	5300	5000
Year 2	5000	6%	10300	618	0	10918	10300
Year 3	5000	6%	15918	955.08	0	16873.08	15918
Year 4	5000	6%	21873.08	1312.385	500	22685.46	21873.08
Year 5	5000	6%	27685.46	1661.128	0	29346.59	27685.46

At each subsequent renewal We will inform You of the amount available for Reserve Benefit in your policy schedule.

This benefit covers

i. Out-patient expenses. This includes

- Diagnostic Tests
- Vaccinations
- Pharmacy
- Consultations with a Medical Practitioner , Physiotherapist ,Dietician, Speech therapist, Psychologist
- Dental expenses
- Special health foods and supplements)

ii. Medical expenses incurred on inpatient and/or outpatient treatment. This includes

- Co-payment and / or Deductible for any health insurance claim
- Standard non-payable items under any health insurance claim
- Other Medical Expenses not covered under any medical insurance
- Additional inpatient medical expenses after exhaustion of sum insured.

iii. Continuation of cover

If the Policy has been renewed with Us for a continuous period of 5 years, , then the Insured Person has an option to pay upto 50% of the renewal premium from accrued Reserve Benefit for subsequent year(s), in such cases portion of renewal premium would be deducted from the accumulated Reserve Benefit Sum Insured. Provided that

- We receive a written request 30 days in advance of the renewal due date from the Insured Person(s)
- There is sufficient Reserve Benefit Sum Insured to pay that portion of renewal premium

If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Reserve Benefit sum insured plus bonus amount for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with Us on a Family Floater basis then the Reserve Benefit sum insured plus bonus that will be carried forward for credit in such renewed Policy shall be the total of all the Insured Persons migrating to a family floater plan.

If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/individual policies then the un-utilised Reserve Benefit sum insured plus bonus amount of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each renewed policy

Bonus on the Reserve Benefit sum insured shall not accrue if the Policy is not renewed with us within the Grace Period.

Section. 6. Deductible

Where optional Deductible is chosen, then all claims made for benefits listed Section 1 of the Policy will be payable only if the aggregate of covered eligible Medical Expenses, in respect to Hospitalisation (s) in a Policy Year is in excess of the Deductible as stated in the Schedule. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

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

- The Deductible will apply on Individual basis in case of individual Sum Insured Policy and on Family Floater basis in case of Family Floater Policy.
- A Deductible does not reduce the Sum Insured.

If opted will apply to all Insured Person (s) under the Policy

Section. 7. Waiting Period and Exclusions

a) Waiting Periods

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

i) **30-day Waiting Period – Code Excl03**

I. 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.

II. This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.

III. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii) **Specified disease/procedure waiting period- Code- Excl02**

I. Expenses related to the treatment of the listed Conditions, surgeries/treatments as mentioned in the table below shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident**.

II. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of **Sum Insured** increase.

III. 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.

IV. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

V. 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.

VI. List of specific diseases/procedure:

Organ / Organ System	Illness / diagnoses (irrespective of treatments medical or surgical)	Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)
Ear, Nose & Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for Nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
Orthopaedic	• Non infective arthritis • Gout and Rheumatism	• Joint replacement surgeries

	• Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	
Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Hemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia
Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	• Nil
Others	• NIL	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/organs whether or not described above)	• Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc	• Nil

iii) **Pre- Existing Diseases: Code- Excl01**

I. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

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

III. 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.

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

b) General exclusions

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

Non Medical Exclusions	i) War or similar situations: Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy(whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. ii) 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. iii) Intentional self injury or attempted suicide while sane or insane. iv) Hazardous or Adventure sports: **Code**-Excl09 Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
Medical Exclusions	i. Investigation & Evaluation: Code Excl04 a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded. b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded. ii. Rest Cure, rehabilitation and respite care–Code – Excl05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes: a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons. b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs. iii. Obesity/Weight control: Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: a. Surgery to be conducted is upon the advice of the doctor b. The surgery/procedure conducted should be supported by clinical protocols c. The member has to be 18 years of age or older and d. Body Mass Index (BMI) i. Greater than or equal to 40 or, ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: 1. Obesity related cardiomyopathy 2. coronary heart disease

3. severe sleep apnoea
4. uncontrolled type2 diabetes

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

v. Cosmetic or plastic surgery: Code – Excl08:Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to 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. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12

vii. 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

viii. 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

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

x. 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

xi. 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

xii. 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.

xiii. 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.

xiv. Aggregate Deductible - We are not liable for Claims/Claim amount falling within Aggregate Deductible limit if opted and as mentioned on the Schedule of Coverage in the Policy Schedule.

	xv.	Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
	xvi.	Any Insured Person's participation or involvement in naval, military or air force operation.
	xvii.	Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
	xviii.	Congenital external diseases, defects or anomalies,
	xix.	Stem cell harvesting.
	xx.	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).
	xxi.	Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
	xxii.	Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
	xxiii.	Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
	xxiv.	Vaccination including inoculation and immunisations (Except post Animal bite treatment),
	xxv.	Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergohealth.com.
	xxvi.	Treatment taken on Outpatient basis
	xxvii.	The provision or fitting of hearing aids, spectacles or contact lenses.
	xxviii.	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.
	xxix.	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.
	xxx.	Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergohealth.com
	xxxi.	Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

Section. 8. General Terms and Conditions

a. Conditions to be followed

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

b. Disclosure of Information

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

c. Policy Period

The premium for the policy will remain the same for the policy period as mentioned in policy schedule. The policy will be issued for a period of 1/2/3 year(s).

d. Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India. For the purpose of policy issuance, the premium will be computed basis the city of residence provided by the insured person in the proposal form. The premium that would be applicable zone wise and the cities defined in each zone are as under:

- Delhi NCR/Mumbai MMR- Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida ,Mumbai, Navi Mumbai , Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai, Virar.
- Rest of India- All other cities
- The premium will be modified in case of midterm address change involving migration from one zone to another and would be calculated on pro-rata basis.

e. Insured Person

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

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

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

f. Loadings

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading or exclusion or both as the case may be through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days. We will issue Policy only after getting Your consent and additional premium (if any). Please visit our nearest branch to refer our underwriting guidelines if required.

Pl Note:
The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section 7 a i),ii) & iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

g. Notification of Claim

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

f. Cashless Service:

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

g. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information We may request to establish the circumstances of the claim, its

quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include but is not limited to the following:

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

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

i. Claims Payment

i) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
ii) We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Your death, we will make payment to the Nominee (as named in the Schedule), payments under this Policy shall only be made in Indian Rupees within India.
iii) The assignment of benefits payable under this Policy shall be subject to applicable law. .

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

v) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after Hospitalisation in the case of an emergency.

vi) Provision for Penal Interest

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

vii) We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017.

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

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

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

j. 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.

k. Non Disclosure or Misrepresentation:

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:
   a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule ; and
   b) the claim under such Policy if any, shall be prejudiced.

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

   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 j i above.

l. Moratorium Period

After completion of eight continuous years under this **Policy** no look back would 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 eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this Policy shall be contestable except for proven fraud & permanent exclusions specified in the policy contract. The Policy would however be subject to all limits, sub limits, co-payments, Deductibles as per the policy contract.

m. 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.

n. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

o. Endorsements

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

p. Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

q. 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.

r. 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.

s. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on Portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

t. Migration

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

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

u. Change of Policyholder

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

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

v. Notices

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

i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement

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

iii) No insurance agents, brokers, other person/ entity is authorised to receive any notice on Our behalf.

w. Dispute Resolution Clause

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

x. Cancellation (Other than Free Look)

a. In-patient Benefits

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

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

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

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

b. Reserve Benefit

In case Your policy is terminated in conjunction with point a) as above or is not renewed with Us in time including the grace period, then any unclaimed accumulated Reserve Benefit would be available for reimbursement for a claim over the next 12 months from the date of cancellation without any further credit of bonus amount.

y. Free Look Period

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

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

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

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

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

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

z. Waiver of Deductible

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

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

ii. This option for waiver of Deductible shall be exercised by the Insured Person during the age group of 55 to 60 years, and certainly at the time of renewal only.
Or
At the beginning of 6th policy year i.e ; provided that it has been renewed with Us continuously and without any interruption.

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

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

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

Section. 9. Other Important Terms You should know

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

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

Def. 2. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an **Insured Person** participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

Def. 3. **Age** or **Aged** means completed years as at the Commencement Date.

Def. 4. **Alternative treatments** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Def. 5. **AYUSH HOSPITAL** means an AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner*(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:
    i. Having at least 5 in-patient beds;
    ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 6. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner*(s) on day care basis without in-patient services and must comply with all the following criterion:

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

Def. 7. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Def. 8. **Bank Rate** shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 9. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

Def. 10. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 11. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 12. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position

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

Def. 13. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

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

Def. 15. **Cumulative Bonus (Multiplier Benefit)** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 16. **Day Care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—
-has qualified nursing staff under its employment;
-has qualified medical practitioner/s in charge;
-has a fully equipped operation theatre of its own where surgical procedures are carried out;
-maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 17. **Day Care Treatment** means medical treatment, 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,
ii. which would have otherwise required a Hospitalisation of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition

Def. 18. **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. 19. **Dental treatment** means treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 20. **Dependents** means only the family members listed below:
i) Your legally married spouse as long as she continues to be married to You;
ii) Your children Aged between 91 days and 25 years if they are unmarried
iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Health Wallet Policy.
iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Health Wallet Policy.
All Dependent parents must be financially dependent on You.

Def. 21. **Dependent Child** means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 22. **Domiciliary Hospitalisation** medical treatment for an illness/disease/injury which in the normal course would require a care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

Def. 23. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event o f misrepresentation, mis-description or non-disclosure of any material fact.

Def. 24. **Emergency** means a severe 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. 25. **Emergency Care** means management for a severe 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. 26. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 27. **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. 28. **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 qualified nursing staff under its employment round the clock,
- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified 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. 29. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum 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. 30. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment

a) Acute Condition means 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 means a disease, illness, or injury that has one or more of the following characteristics:
- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
—it needs ongoing or long-term control or relief of symptoms
— it requires your rehabilitation or for you to be specially trained to cope with it
—it continues indefinitely
—it comes back or is likely to recur.

Def. 31. **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. 32. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 33. **Insured Person means** You and the persons named in the Schedule.

Def. 34. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 35. **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. 36. **Material Facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 37. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 38. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

Def. 39. **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. 40. **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. 41. **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. 42. **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. 43. **Network Provider** means Hospitals enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

Def. 44. **Non Network mean**s any Hospital, day care centre or other provider that is not part of the Network

Def. 45. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 46. **OPD treatment** means the treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient

Def. 47. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Def. 48. **Pre-existing Condition** 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. 49. **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. 50. **Pre- Hospitalisation** Medical Expenses means the Medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 51. **Post- Hospitalisation** Medical Expenses means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

Def. 52. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any) and the policy schedule (as the same may be amendefrom time to time).

Def. 53. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 54. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 55. **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. 56. **Reasonable & 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. 57. **Room Rent** means the amount charged by a hospital for the occupancy of a bed on per day (24 hrs) basis and shall include associated medical expenses.

Def. 58. **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. 59. **Surgery** or **Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 60. **Unproven/Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 61. **We/Our/Us** means the HDFC ERGO Health Insurance Ltd..

Def. 62. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section. 10. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, You can contact HDFC EGRO Health through:

- Website : www.hdfcergohealth.com
- Toll Free : 1800-102- 0333
- Fax : 1800- 425- 4077
- Courier : Claims Department,

HDFC ERGO Health Insurance Ltd
Ground floor, Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad-500 034

Or
HDFC ERGO Health Insurance Ltd.
iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III,
Gurgaon-122016, Haryana

Additional Note**: Please refer to the list of empanelled network centers on our website Or the list provided in the welcome kit.**

Section. 11. Redressal of Grievance

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

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

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

The Grievance Cell, HDFC ERGO Health Insurance Ltd., 2nd and 3rd Floor, iLABS Centre, Plot No 404-405, Udyog Vihar, Phase III, Gurgaon, Haryana-122016.

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

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

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - ShriKuldip Singh Office of the Insurance Ombudsman,	**Gujarat, Dadra & Nagar Haveli,**

JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	**Daman and Diu.**
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	**Karnataka.**
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	**Madhya Pradesh Chattisgarh.**
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	**Orissa.**
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	**Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.**
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	**Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).**
DELHI - ShriSudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	**Delhi.**

Tel.: 011 - 23232481/23213504 **Email: bimalokpal.delhi@ecoi.co.in**	
GUWAHATI - ShriKiriti .B. Saha **Office of the Insurance Ombudsman,** **JeevanNivesh, 5th Floor,** **Nr. Panbazar over bridge, S.S. Road,** **Guwahati – 781001(ASSAM).** **Tel.: 0361 - 2632204 / 2602205** **Email: bimalokpal.guwahati@ecoi.co.in**	**Assam,** **Meghalaya,** **Manipur,** **Mizoram,** **Arunachal Pradesh,** **Nagaland and Tripura.**
HYDERABAD - Shri I. Suresh Babu **Office of the Insurance Ombudsman,** **6-2-46, 1st floor, "Moin Court",** **Lane Opp. Saleem Function Palace,** **A. C. Guards, Lakdi-Ka-Pool,** **Hyderabad - 500 004.** **Tel.: 040 - 67504123 / 23312122** **Fax: 040 - 23376599** **Email: bimalokpal.hyderabad@ecoi.co.in**	**Andhra Pradesh,** **Telangana,** **Yanam and** **part of Territory of Pondicherry.**
JAIPUR - Smt. SandhyaBaliga **Office of the Insurance Ombudsman,** **JeevanNidhi – II Bldg., Gr. Floor,** **Bhawani Singh Marg,** **Jaipur - 302 005.** **Tel.: 0141 - 2740363** **Email: Bimalokpal.jaipur@ecoi.co.in**	**Rajasthan.**
ERNAKULAM - Ms. PoonamBodra **Office of the Insurance Ombudsman,** **2nd Floor, Pulinat Bldg.,** **Opp. Cochin Shipyard, M. G. Road,** **Ernakulam - 682 015.** **Tel.: 0484 - 2358759 / 2359338** **Fax: 0484 - 2359336** **Email: bimalokpal.ernakulam@ecoi.co.in**	**Kerala,** **Lakshadweep,** **Mahe-a part of Pondicherry.**
KOLKATA - Shri P. K. Rath **Office of the Insurance Ombudsman,** **Hindustan Bldg. Annexe, 4th Floor,** **4, C.R. Avenue,** **KOLKATA - 700 072.** **Tel.: 033 - 22124339 / 22124340** **Fax : 033 - 22124341** **Email: bimalokpal.kolkata@ecoi.co.in**	**West Bengal,** **Sikkim,** **Andaman & Nicobar Islands.**
LUCKNOW -Shri Justice Anil Kumar Srivastava **Office of the Insurance Ombudsman,** **6th Floor, JeevanBhawan, Phase-II,** **Nawal Kishore Road, Hazratganj,** **Lucknow - 226 001.** **Tel.: 0522 - 2231330 / 2231331** **Fax: 0522 - 2231310** **Email: bimalokpal.lucknow@ecoi.co.in**	**Districts of Uttar Pradesh :** **Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.**
MUMBAI - ShriMilind A. Kharat	**Goa,**

Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	**Mumbai Metropolitan Region excluding Navi Mumbai & Thane.**
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	**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@ecoi.co.in	**Bihar, Jharkhand.**
PUNE - ShriVinaySah Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	**Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.**

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

Schedule of benefits - Health Wallet Individual

Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00, 20.00, 25.00 & 50,00
1a) In-patient Treatment	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 90 Days
1d) Day Care Procedures	All Day Care Procedures Covered
1e) Domiciliary Treatment	Covered
1f) Organ Donor	Covered
1g) Ambulance	Upto Rs.2,000 per Hospitalisation
1h) Ayush Treatment **This benefit is not applicable if optional Deductible is chosen**	Covered
1i) Recovery Benefit **This benefit is not applicable if optional Deductible is chosen**	Rs 10,000 for hospitalisation exceeding consecutive 7 days
1j) Worldwide Emergency Care	50% of Sum Insured upto a maximum of Rs.20 lacs
2) Restore Benefit	Equal to 100% of Basic Sum Insured
3) Preventive Health Check-up	As per grid mentioned in the benefit
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal
5) Reserve Benefit per Insured Person per Policy Year (Rs)	5,000; 10,000; 15,000; 20,000 & 25,000
6) Deductible (Optional) per Insured Person per Policy Year (Rs in Lakh)	2.00; 3.00; 5.00 & *10.00 *10.00 deductible available for SI of 20 lacs and above

Schedule of benefits Health Wallet - Family Floater

Basic Sum Insured per Policy per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00, 20.00, 25.00 & 50,00
1a) In-patient Treatment	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 90 Days
1d) Day Care Procedures	All Day Care Procedures Covered
1e) Domiciliary Treatment	Covered
1f) Organ Donor	Covered
1g) Ambulance	Upto Rs.2,000 per Hospitalisation
1h) Ayush Treatment **This benefit is not applicable if optional Deductible is chosen**	Covered
1i) Recovery Benefit **This benefit is not applicable if optional Deductible is chosen**	Rs 10,000 for hospitalisation exceeding consecutive 7 days
1j) Worldwide Emergency Care	50% of Sum Insured upto a maximum of Rs.20 lacs
2) Restore Benefit	Equal to 100% of Basic Sum Insured
3) Preventive Health Check-up	As per grid mentioned in the benefit
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal
5) Reserve Benefit per Insured Person per Policy Year (Rs)	5,000; 10,000; 15,000; 20,000 & 25,000
6) Deductible (Optional) per Insured Person per Policy Year (Rs in Lakh)	2.00; 3.00; 5.00 & *10.00 *10.00 deductible available for SI of 20 lacs and above

Annexure I – List of Non-Medical Expenses

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR

9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY