HDFC ERGO General Insurance Company Limited

Policy Wording

HEALTH SURAKSHA - CSC

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

SECTION. 1.BENEFITS

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

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

i. In-patient Treatment
The Medical Expenses for:

a. Room rent, boarding expenses,

b. Nursing,

c. Intensive care unit,

d. A Medical Practitioner,

e. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,

f. Medicines, drugs and consumables,

g. Diagnostic procedures,

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

ii. Pre-Hospitalisation
The Medical Expenses incurred due to an Illness in 60 days immediately before the Insured Person was Hospitalised, provided that:

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

b. We have accepted an inpatient Hospitalisation claim under Benefit 1i) or Benefit 1iv)

iii. Post-hospitalisation
The Medical Expenses incurred in 90 days immediately after the Insured Person was discharged post Hospitalisation provided that:

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

b. We have accepted an inpatient Hospitalisation claim under Benefit 1i) or Benefit 1iv).

iv. Day Care Procedures
The Medical Expenses for a day care procedure or surgery mentioned in the list of Day Care Procedures in this Policy where the procedure or surgery is taken by the Insured Person as an inpatient for less than 24 hours in a Hospital (but not the outpatient department of a Hospital). The expenses on Day Care Treatment at a healthcare facility which is NOT a Hospital will not be covered.

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

a. The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the Medical Expenses of any necessary medical treatment for the entire period, and

b. If We accept a claim under this Benefit We will not make any payment for Post-Hospitalisation expenses but We will pay Pre-hospitalisation expenses for up to 60 days in accordance with 1 ii) above, and

c. No payment will be made if the condition for which the Insured Person requires medical treatment is:

1. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,

2. Arthritis, Gout and Rheumatism,

3. Chronic Nephritis and Nephritic Syndrome,

4. Diarrhoea and all type of Dysenteries including Gastroenteritis,

5. Diabetes Mellitus and Insupidus,

6. Epilepsy,

7. Hypertension,

8. Psychiatric or Psychosomatic Disorders of all kinds,

9. Pyrexia of unknown Origin.

vi. Organ Donor The Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

i. The organ donor is any person in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules,

ii. The organ donated is for the use of the Insured Person, and

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

iv. We have accepted an inpatient Hospitalisation claim under Benefit 1i).

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

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

b. We have accepted an inpatient Hospitalisation claim under Benefit 1i) & 1viii).

We will not cover Emergency Ambulance expenses for

1. Claims which have NOT been admitted under 1 i) and 1 iv)

2. A non- Emergency

3. NON registered healthcare or ambulance service provider ambulances.

viii. AYUSH Benefit
We will reimburse the expenses incurred as the Medical Expenses for In-patient treatment taken under Ayurveda, Unani, Sidha or Homeopathy in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board on Health or any other suitable institutions provided that:

i. Hospitalisation is not for any evaluation or investigation

ii. If We accept any claim under this benefit, then We will not make any payment under allopathic treatment of the same Insured Person and the same Illness or Accident under this policy.

ix. Newborn baby
We will cover Medical Expenses for any medically necessary treatment described as Inpatient treatment Benefit while the Insured Person (the Newborn baby) is Hospitalised during the Policy Period as an inpatient provided a proposal form is submitted for the insurance of the newborn baby within 90 days after the birth, and We have accepted the same and received the premium sought.

Under this benefit, Coverage for newborn baby will incept from the date the premium has been received.

The coverage is subject to the policy exclusions, terms and conditions.

This Benefit is applicable if Maternity benefit is opted and We have accepted a maternity claim under this Policy.

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Optional Benefits

SECTION. 2. OPTIONAL BENEFITS (AVAILABLE IN SELECTIVE PLANS ON PAYMENT OF ADDITIONAL PREMIUM)

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

The benefits below are optional and each is only effective if shown in the Schedule to be effective.

i. **Maternity Expenses** We will pay the Medical Expenses for a delivery (including caesarean section) while Hospitalised or the lawful medical termination of pregnancy during the Policy Period from the commencement of the first Health Suraksha policy with us, limited upto 2 deliveries; or 1 delivery & 1 termination; or 2 terminations during the lifetime of the Insured Person, provided that:

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

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

   c. We will cover the Medical Expenses incurred for the medically necessary treatment of the new born baby upto the amount stated in the Schedule of Benefits unless the new born baby is covered under 1 ix),

   d. This benefit is available for Self or Spouse (as may be applicable) in a family floater under this policy, and

   e. Pre- and post-hospitalisation expenses under 1ii) and 1iii) are not covered under this benefit, and

   f. The Insured Person must have been an Insured Person under Health Suraksha Policy for a period of 4 years continuously and without any break, and

   g. We will not cover ectopic pregnancy under this benefit (although it shall be covered under 1i)).

ii. **Outpatient Dental Treatment**
If You renew this Policy with Us for 3 consecutive years without a break, then from the fourth year onwards We will pay 50% of the reasonable costs of any necessary dental treatment taken from a Network dentist by an Insured Person who has been covered under this policy benefit for the previous 3 Policy Years, provided that:

   a. Our maximum liability shall be limited to the amount specified in the Schedule of Benefits, and

   b. We will only pay for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, and

   c. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury due to an accident or cancer.

iii. **Spectacles, Contact Lenses, Hearing Aid**
In every third year that an Insured Person is insured without a break under a Health Suraksha Policy with Us, We will pay up to 50% of the actual cost of either:

   a. One pair of spectacles or contact lenses, or

   b. A hearing aid, excluding batteries.

   Provided that:

   i. If the costs claimed are incurred as Outpatient Treatment expenses then these items must be prescribed by a Network EYE/ENT specialised Medical Practitioner, and

   ii. Our maximum liability shall be limited to the amount mentioned in the Schedule of Benefits, and

   iii. Under a Family Floater, Our liability shall be limited to either one pair of spectacles or hearing aid per family.

iv. **E-Opinion in respect of a Critical Illness**

   a. If an Insured Person suffers a Critical Illness during the Policy Period, and no previous claim has been made for this E-Opinion benefit in the Policy Period, then at the Insured Person's request, We will arrange a second opinion from a Medical Practitioner selected by the Insured Person from Our panel. The second opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person, and the second opinion will be sent directly to the Insured Person by the Medical Practitioner.

   b. In opting for this benefit and deciding to obtain an E-opinion, each Insured Person expressly notes and agrees that:

      1. It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which person from Our Panel to take the E-opinion and the use (if any) to which the E-opinion so obtained is put.

      2. We do not provide an E-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same, or the use to which the E-opinion is put.

      3. We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any E-opinion or for any consequences of any action taken or not taken in reliance thereon.

v. **Convalescence Benefit** If We have accepted a claim under Benefit 1 i) and the period of hospitalisation has exceeded 10 consecutive and continuous days, then We will pay a lumpsum amount towards convalescence, provided that Our maximum liability will be limited to the amounts specified in the Schedule of benefits.

SECTION 3. CRITICAL ILLNESS BENEFIT – OPTIONAL BENEFIT

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

i. If the Schedule shows that the Critical Illness benefit is effective, then We will pay the Critical Illness Sum Insured as a lump sum in addition to Our payment under 1)i), provided that:

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

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

ii. We will not make any payment if:

   a. The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period or the Insured Person has not previously been insured continuously and without interruption under this Health Suraksha Policy.

   b. This benefit shall automatically terminate upon the occurrence of Critical Illness, without prejudice of Our obligation to make payment, with reference to that Insured Person.

   c. If mentioned in the policy schedule this benefit will be applicable to the eldest member of the family

iii. Benefits under section 1 and 2(if opted) will continue even after payout under Section 3. Insured will be eligible for any claim under Section 1 and 2 upto our maximum liability restricted to the amount stated in schedule of benefits.

iv. This benefit will be provided with a life-long renewability

SECTION 4. HOSPITAL DAILY CASH BENEFIT – OPTIONAL BENEFIT

Claims made in respect of any of the benefits below will not be subject to the Sum Insured. However would not be entitled to avail cumulative bonus in the subsequent year

If the Schedule shows that the Hospital Daily Cash benefit is effective, then We will pay a daily cash amount for each continuous and completed period of 24 hours that the Insured Person is Hospitalised in addition to Our payment under 1)I), provided that:

a. We will pay twice the daily cash amount for each continuous and completed

period of 24 hours that the Insured Person spends in an intensive care unit, subject to a maximum of seven days.

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

c. We have accepted an inpatient Hospitalisation claim under Benefit 1i), and

d. If mentioned in the policy schedule this benefit will be applicable to the eldest member of the family

This benefit will be provided with a life-long renewability

SECTION 5. REGAIN BENEFIT – OPTIONAL BENEFIT

This benefit is optional and only effective if mentioned in the Schedule.

If the Basic Sum Insured is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable, then it is agreed that a Regain Sum Insured (equal to 100% of the Basic Sum Insured) will be automatically available for the particular policy year, provided that:

a. The Regain Sum Insured will be enforceable only after the Basic Sum Insured inclusive of the no claim Bonus if any has been completely exhausted in that year; and

b. The Regain Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1i) to 1 ix).

The Regain Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/ disease (including its complications) for which a claim has been paid in the current policy year under Section Section 1i) to 1 ix).

c. The Regain Sum Insured will only be applied once for the Insured Person during a Policy Year;

d. If the Regain Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

If the Policy is a Family Floater, then the Regain Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Sum Insured was exhausted.

The Regain benefit would be applicable on benefits under Section Section 1i) to 1 ix).Only on Sum Insured of Rs. 3 lacs and above.

If Section 5 is selected then Section 7 cannot be opted for.

Once the Regain benefit is availed, it cannot be withdrawn by the Insured at subsequent renewals.

SECTION 6. ENHANCED CUMULATIVE BONUS BENEFIT– OPTIONAL BENEFIT

This benefit is optional and only effective if mentioned in the Schedule.

This benefit shall be subject to all guidelines in section 8, except that Cumulative Bonus stated in Section 8a iii shall automatically increase to 10% and the maximum cumulative bonus shall not exceed 100% of Base Sum Insured. Cumulative bonus thus applied would automatically decrease by 10% of the Basic Sum Insured in that following Policy Year in case of a claim.

Once the Enhanced Cumulative Bonus benefit is availed by the Insured, it cannot be withdrawn by the Insured at subsequent renewals.

SECTION 7. CO-PAYMENT – OPTIONAL BENEFIT

If the Schedule shows that the Co-Payment is effective, then Co-Pay option as selected by the insured and displayed on the schedule as a percentage will be applicable on all claims admissible under Benefit in Section 1i) to 1 ix) and Section 2 l)

If Section 7 is selected then Section 5 cannot be opted for.

Once the Co-Payment option is availed by the Insured, it cannot be withdrawn by the Insured at subsequent renewals

SECTION 8. RENEWAL INCENTIVES

a. Cumulative Bonus

i. If no claim has been made under the Section 1 of this Policy and the Policy is renewed with Us without any break, We will apply a cumulative bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 5% of the Basic Sum Insured for this Policy Year. The maximum cumulative bonus shall not exceed 50% of the Basic Sum Insured in any Policy Year.

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

iii. If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the cumulative bonus by 5% of the Basic Sum Insured in that following Policy Year. There will be no impact on the inpatient sum insured only the accrued cumulative bonus will be decreased.

iv. Portability benefits will be offered to the extent of sum of previous sum insured and accrued cumulative bonus (if opted for), portability benefit shall not apply to any other additional increased sum insured.

v. In policies with a two year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year i.e. at the renewal of the policy; the cumulative bonus of two completed years (One policy period) shall be applied.

b. Health Check-up

i. If no claim has been made in respect of any benefits and You have maintained an Health Suraksha Policy with Us for a period of 4 years without any break, then in the every fifth year, We will pay upto the percentage (mentioned in the Schedule of Benefits) of the Sum Insured for this Policy Year or the subsequent Policy Years (whichever is lower) towards the cost of a medical check-up for those Insured Persons who were insured for the number previous Policy Years mentioned in the Schedule.

ii. Incase of family floater, if any of the members have made a claim under this policy, the health checkup benefit will not be offered to the whole family.

SECTION. 9.EXCLUSIONS

A. Waiting Periods

All claims payable will be subject to the waiting periods specified below:

i General waiting period of 30 days for all claims payable under the Policy except claims arising due to an Accident.

ii A waiting period of 24 months shall apply to the treatment, whether medical or surgical, of the disease/ conditions mentioned below. Additionally the said 24 months waiting period shall be applicable to all surgical procedures mentioned under surgeries in the following table, irrespective of the disease/condition for which the surgery is done, except claims payable due to the occurrence of cancer.

a. **Illnesses:** Internal Congenital diseases, non infective arthritis; calculus diseases of gall bladder including cholecystitis and urogenital system e.g. Kidney stone, Urinary Bladder Stone; Pancreatitis, Ulcer and erosion of stomach and duodenum;Gastro Esophageal Reflux Disorder (GERD); All forms of Cirrhosis (Pls note: all forms of cirrhosis due to alcohol will be excluded);Perineal Abscesses; Perianal Abscesses; cataract; fissure/ fistula in anus, hemorrhoids, pilonidal sinus,; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); osteoarthritis and osteoporosis; polycystic ovarian diseases; Fibroids (fibromyoma) ; sinusitis; Rhinitis; Tonsillitis and skin tumorsunless malignant; Benign Hyperplasia of Prostate.

b. **Treatments:** adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C);joint replacement; myomectomy for fibroids; surgery of genito urinary system unless necessitated by malignancy; surgery on prostate; cholecystectomy; surgery of hernia; surgery of hydrocele/ Rectocele; surgery for prolapsed inter vertebral disk; Joint replacement surgeries surgery of varicose veins and varicose ulcers; Surgery for Nasal septum deviation, nasal concha resection,

iii 48 months waiting period for all Pre-existing Conditions declared and/or accepted at the time of application.

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PI Note:
Coverage under the policy for any past illness/condition or surgery is subject to the same being declared at the time of application by You or the Insured Person or anyone acting on behalf of You or an Insured Personand accepted by Us without any exclusion

B. Reduction in waiting periods

1. If the Proposed Insured is presently covered and has been continuously covered without any lapses under:

   a. any health insurance plan with an Indian non life insurer as per guidelines on portability, OR

   b. any other health insurance plan from Us,

   Then:

   a The waiting periods specified in Section 9A I), ii) and iii) of the Policy stand deleted; AND:

   b. The waiting periods specified in the Section 9 A I), ii) and iii) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy ; AND

   c. If the proposed Sum Insured for a proposed Insured Person is more than the Sum Insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the Sum Insured and any other accrued sum insured under the previous health insurance policy.

2. The reduction in the waiting period specified above shall be applied subject to the following:

   a. We will only apply the reduction of the waiting period if We have received the database and claim history from the previous Indian insurance company (if applicable)

   b. We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation and information.

   c. We will retain the right to underwrite the proposal as per Our underwriting guidelines.

   d. We shall consider only completed years of coverage for waiver of waiting periods. Policy Extensions if any sought during or for the purpose of porting insurance policy shall not be considered for waiting period waiver.

C. General Exclusions

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

i. War or any act of war, invasion, act of foreign enemy, war like operations (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.

i Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide or suicide while sane or insane.

i Any Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in a professional or semi professional nature.

iv. The abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.

v. Treatment of Obesity and any weight control program,

vi. Psychiatric, mental disorders (including mental health treatments)and, sleep-apnoea, Parkinson and Alzheimer's disease, ,general debility or exhaustion (“run-downcondition”).

vi. Congenital external diseases, defects or anomalies, genetic disorders.

vi Stem cell implantation or surgery, or growth hormone therapy. Venereal disease, sexually transmitted disease or illness; “AIDS” (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus) including but not limited to conditions related to or arising out of HIV/ AIDS such as ARC (AIDS related complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.

ix. Save as and to the extent provided for under 2 I), pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to a claim under1 i) for in-patient treatment only.

x. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services.

xi. Save as and to the extent provided for under 2 ii), dental treatment and surgery of any kind, unless requiring Hospitalisation.

xi Expenses for donor screening, or, save as and to the extent provided for in 1vi), the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery).

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

xiv. Circumcisions (unless necessitated by illness or injury and and forming part of treatment); treatment for correction of eye due to refractive error, aesthetic or change-of-life treatments of any description such as sex transformation operations.

xv. Plastic surgery or cosmetic surgery or treatments to change appearance unless unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.

xvi. Conditions for which Hospitalisation is NOT required

xvi Experimental, investigational or unproven treatment devices and pharmacological regimens.

xvi Admission primarily for diagnostic purposes not related to illness for which Hospitalisation has been done.

xix. Save as and to the extent provided for under 2 v), any Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.

xx. Save as and to the extent provided for under 1viii), any non allopathic treatment.

xxi. Preventive care, vaccination including inoculation and immunisations (except in case of post- bite treatment), any physical, psychiatric or psychological examinations or testing; enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise coveredclaim.

xxi Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

xxi Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs(except patient`s diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies, and vitamins and tonics unless vitamins and tonics are certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

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

or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

xxv. Save as and to the extent provided in 2 iii), the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

xxvi. Any treatment or part of a treatment that is not of a reasonable charge , not medically necessary; treatments or drugs not supported by a prescription.

xxvii. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).

xxviii. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the Insured, as per our Underwriting guidelines.

xxix. Any non medical expenses mentioned in Appendix II of the policy document.

SECTION. 10. GENERAL CONDITIONS

a. Condition precedent

The fulfilment of the terms and conditions of this Policy (including the payment of premium by the due dates mentioned in the Schedule) in so far as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

b. Geography

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

c. Insured person

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

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

Any Insured Person in the policy has the option to migrate to any 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 portabilityguidelines.

d. 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 SumInsured).

For Example: Consider a male aged 35 who is undergoing treatment for hypertension.

Age	Hypertension	Treatment	Systolic	Diastolic	loading
35	Yes	Yes	110-145	70-95	10%
35	Yes	Yes	146-160	70-95	20%
35	Yes	Yes	110-140	96-105	20%
35	Yes	Yes	>160	Any	Reject
35	Yes	Yes	Any	>105	Reject

Please note that this example is for illustrative purposes only, the decisions may vary based on age, co morbidities etc.

We will not apply any additional loading on your policy premium at renewal based on claim experience.

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the 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.

Please note that 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.

e. Notification ofClaim

Sr. No.	Treatment, Consultation or Procedure:	We or Our TPA must be informed:
1.	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.
2.	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.
3.	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.
4.	If any treatment, consultation or procedure for which a claim may be made is required in an emergency:	Within 7 days of completion of such treatment, consultation or procedure.
5.	In all other cases:	Of any event or occurrence that may give rise to a claim under this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorise such treatment, consultation or procedure.

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

If any time period is specifically mentioned under Section 1-5, then this shall supersede the time periods mentioned above.

f. Cashless Service

Sr. No.	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
1.	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation.
2.	If any treatment, consultation or procedure for which a claim may be made in an emergency:	Network Hospital	We will provide cashless service by making payment to the extent of our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation.

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

g. Supporting Documentation & Examination

The Insured Person shall provide Us with any documentation and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of our request or the Insured Person's discharge from Hospitalisation or completion of treatment. Such documentation will include but is not limited to the following:

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

ii. Original Bills with detailed breakup of charges (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

iii. Original paymentreceipts

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

v. Discharge Summary, with Date of admission and discharge, clinical history, past history, procedure details and details of treatment taken.

vi. Invoice/ Sticker of transplants

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

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

ix. Prescriptions that name the Insured Person 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.

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

i. Claim Payment

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

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

iii. 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 could reasonably have minimised the costs incurred, 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.

iv. 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 claimAll claims will be settled in accordance with the applicable regulatory guidelines, including IRDA (Protection of Policyholders Regulation), 2002. 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 IRDA (Protection of Policyholders Regulation), 2002, we shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

j. Fraud

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and l benefits paid under it shall be forfeited.

k. Contribution

If at the time when any claim is made under this Policy, insured has two or more policies from one or more Insurers to indemnify treatment cost, which also covers any claim (in part or in whole) being made under this Policy, then the Policy holder shall have the right to require a settlement of his claim in terms of any of his policies. The insurer so chosen by the Policy holder shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen policy.

Provided further that, If the amount to be claimed under the Policy chosen by the Policy holder, exceeds the sum insured under a single Policy after considering the deductibles or co-pay (if applicable), the Policy holder shall have the right to choose the insurers by whom claim is to be settled. In such cases, the respective insurers may then settle the claim by applying the Contribution clause . This clause shall only apply to indemnity sections of the policy.

l. Subrogation

The Insured Person must do all acts and things that We may necessarily and reasonably require to enforce/ secure any civil/ criminal rights and remedies or to obtain relief/ indemnity from any other party because of making reimbursement under the Policy. This would be irrespective of whether such necessity has arisen before or after the reimbursement. These subrogation rights must NOT be prejudiced in any manner by the Insured Person. The Insured Person must provide Us with whatever assistance or cooperation is required to enforce such rights. We would deduct any amounts paid or payable and expenses of effecting recovery from any recovery that We make pursuant to this clause and pay the balance to You. This clause is only applicable to indemnity policies and benefits.

m. Alterations to the Policy

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

n. Renewal

This Policy is renewable for life unless the Insured Person or anyone acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or there has been any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

We are NOT under any obligation to:

i. Send renewal notice or reminders.

ii. Renew it on same terms or premium as the expiring Policy. Any change in benefits or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to You at least 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy. You will have the option to migrate to an indemnity health insurance policy available with us at the time of renewal 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.

iii. We will not apply any additional loading on your policy premium at renewal based on claim experience.

We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.

All applications for renewal of the Policy must be received by Us before the end of the Policy Period. A grace period of 30 days for renewing the Policy is available under this Policy. Any disease/condition contracted during the Grace Period will not be covered and will be treated as a Pre-existing Condition.

o. Change ofPolicyholder

The Policyholder may be changed only at the time of renewal. The new

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Policyholder must be a member of the Insured`s person immediate family. Such changes would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without any break in cover.

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

p. Notices

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

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

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

iii. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

q. 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.

r. Termination

i. You may terminate this Policy at any time by giving Us written notice. The cancellation shall be from the date of receipt of such written notice. If no claim has been made under the Policy, then We will refund premium in accordance with the table below:

1 Year Policy Period		2 Year Policy Period		3 Year Policy Period	
Length of time Policy in force	% of premium refunded	Length of time Policy in force	% of premium refunded	Length of time Policy in force	% of premium refunded
Upto 1 Month	75.00%	Upto 1 Month	87.50%	Upto 1 Month	90.00%
Upto 3 Months	50.00%	Upto 3 Months	75.00%	Upto 3 Months	84.00%
Upto 6 Months	25.00%	Upto 6 Months	62.50%	Upto 6 Months	78.00%
Exceeding 6 Months	Nil	Upto 12 Months	48.00%	Upto 12 Months	60.00%
		Upto 15 Months	25.00%	Upto 15 Months	54.00%
		Upto 18 Months	12.00%	Upto 18 Months	30.00%
		Exceeding 18	Nil	Upto 21 Months	20.00%
				Upto 24 Months	18.00%
				Upto 27 Months	15.00%
				Upto 30 Months	10.00%
				Exceeding 30 Months	Nil

ii. We may terminate this Policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by You or any Insured Person or anyone acting on Your behalf or on behalf of an Insured Person. Such termination of the Policy shall be from the inception date or the renewal date (as the case may be) upon 30 days notice and by sending an endorsement in this regard at Your address shown in the Schedule without refund of any premium.

s. Free Look Period

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel Your Policy only if You have not made any claims under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and is not available at the time of renewal of the Policy.

SECTION. 11. INTERPRETATIONS & DEFINITIONS

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

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

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

Def. 3. **Any one Illness** means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nusing Home where treatment may have been taken.

Def. 4. **Alternate Treatments** are form of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian Context.

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

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

Def. 7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 8. **Condonation of delay**
The Company may condone delay in claim intimation/ document submission on merit, where it is proved that delay in reporting of claim or submission of claim documents, is due to reasons beyond the control of the insured.

Notwithstanding the above, delay in claim intimation or submission of claim documents due to reasons beyond the control of the insured shall not be condoned where such claims would have otherwise been rejected even if reported in time.

Def. 9. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

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

b. External Congenital Anomaly - which is in the visible and accessible parts of the body.

Def. 10. **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.

Def. 11. **Co-Payment** is 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. 12. **Critical Illness** means Cancer, Coronary Artery (Bypass) Surgery, First Heart Attack (Myocardial Infarction), Kidney Failure (end stage renal disease), Major Organ Transplantation, Multiple Sclerosis, Paralysis, Stroke, Aorta Graft Surgery, Primary Pulmonary Arterial Hypertension and Heart Valve Replacement; all as defined below only and each is only effective if shown in the Schedule:

i. Cancer of specified severity:

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 &CIN-3.
- Any skin cancer other than invasive malignant melanoma
- 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.
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder

All tumours in the presence of HIV infection

ii. Open Chest CABG:

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/ are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by coronary angiography and the realisation of the surgery has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

- Angioplasty and/or any other intra-arterial procedures
- Any key-hole or laser surgery

iii. First Heart Attack -of Specified Severity:

The first occurrence of 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 this will be evidenced by all of the following criteria:

- A history of of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
- new characteristic electrocardiogram changes
- elevation of infarction specific enzymes, Troponins or other biochemical markers

The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with only elevation of Troponin I or T
- Other acute Coronary Syndromes
- Any type of angina pectoris

iv. Kidney Failure Requiring Regular Dialysis

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 must be confirmed by a specialist Medical Practitioner.

v. Major Organ/Bone Marrow Transplant:

The actual undergoing of transplant of:

- One of the following human organs: heart, lung, liver, pancreas, kidney, that resulted from irreversible end stage failure of the relevant organ or;
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant must be confirmed by a specialist Medical Practitioner.

The following are excluded:

- Other Stem cell transplants
- Where only islets of langerhans are transplanted.

vi. Multiple Sclerosis with persistent symptoms:

The definite occurrence of Multiple Sclerosis.The diagnosis must be supported by all of the following:

- Investigation including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple Sclerosis.
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months.
- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast 1 month apart.
- Other causes of neurological damage such as SLE and HIV are excluded.

vii. Permanent Paralysis of Limbs:

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 paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

viii. Stroke resulting in Permanent symptoms:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue ,thrombosis in an intra-cranial vessel, haemorrhage andembolisation from an extracranial source. The Diagnosis has to be confirmed by a specialist Medical 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.
The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular diseases affecting only the eye or optic nerve or vestibular functions

ix. Aorta GraftSurgery:

The actual undergoing of surgery of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Realisation of the aortic surgery has to be confirmed by a specialist Medical Practitioner (cardiologist/Cardiac Surgeon).

x. Primary Pulmonary Arterial Hypertension:

An increase in the blood pressure in the pulmonary arteries, caused by either an increase in pulmonary capillary pressure, increased pulmonary blood flow or increased pulmonary vascular resistance.

Diagnosis has to be confirmed by a specialist Medical Practitioner (Cardiologist) and evidenced by cardiac catheterization showing a mean pulmonary artery pressure during rest of at least 20 mmHg.

Furthermore right ventricular hypertrophy or have to be medically documented for at least 90 days.

xi. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of Open heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s).The diagnosis of the valve abnormality must be supported by echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty areexcluded.

Def. 13. **Cumulative Bonus** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 14. **Day care Centre** means any institution established for day care treatment of illness and/ or injuries or a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- has qualified nursing staff under its employment; has qualified medical practitioner (s) in charge; has a fully equipped operation theatre of its own where surgical procedures are carried out; maintains daily records of patients and will make these accessible to the Insurance company's authorizedpersonnel.

Def. 15. **Day Care Treatment/ Procedures** means those 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, and

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

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

Def. 16. **Domiciliary Treatment/ Hospitalisation** means medical treatment for an Illness/ disease/ injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

a. The condition of the Patient is such that he/ she is not in a condition to be removed to a Hospital or,

b. The Patient takes treatment at home on account of non availability of room in a Hospital.

Def. 17. **Dependents** means only the family members listed below:

a. Your legally married spouse as long as she continues to be married to You;
b. Your children Aged between 91 days and 21 years if they are unmarried, still financially dependent on You and have not established their own independent households;
c. Your natural parents or parents that have legally adopted You, provided that:

- Parents shall not include Your spouse's parents.

Def. 18. **Dental Treatment** is a treatment carried out by a dental practitioner including examinations, fillings (where appropriate),crowns, extractions and surgery excluding any form of cosmetic surgery/ implants.

Def. 19. **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. 20. **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. 21. **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. 22. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.

Def. 23. **Hospital** means any institution in India 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 those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 24. **Hospitalisation or Hospitalised** means the Insured Person's admission into a Hospital for a minimum of 24 In-Patient care consecutive hours except for specified procedures/ treatment, where such admission could be for a period of less than 24 consecutive hours.

Def. 25. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period 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 o f 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 o f symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

Def. 26. **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. 27. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 28. **In-patient Treatment** means treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.

Def. 29. **Insured Person** means You and the persons named in the Schedule.

Def. 30. **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. 31. **Maternity Expenses** shall include

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during Hospitalisation).

b. Expenses towards lawful medical termination of pregnancy during the policyperiod.

Def. 32. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 33. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

a. **Pre- Hospitalisation Medical Expenses** means the Medical Expenses incurred immediately before the Insured Person is Hospitalised, providedthat:

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

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

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

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

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

Def. 34. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 35. **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. 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. 36. **Newborn Baby** means baby born during the Policy Period and is Aged between 1 day and 90 days, both days inclusive.

Def. 37. **Network Provider** means Hospitals or health care providers enlisted by

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an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

Def. 38. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network.

Def. 39. **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timeliness as well as the address/ telephone number to which it should be notified.

Def. 40. **OPD Treatment** is 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 daycare or inpatient.

Def. 41. **Portability** means transfer by an individual health insurance policy holder (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. 42. **Pre Existing Disease** means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/ or were diagnosed, and/ or received medical advice/ treatment, within 48 months prior to the first policy issued by the insurer.

Def. 43. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def. 44. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 45. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 46. **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. 47. **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. 48. **Room Rent** means the amount charged by a hospital for the occupying of a bed on per day (24 hours) basis and shall include associated medical expenses.

Def. 49. **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 all waiting periods.

Def. 50. **Subrogation** means the the right o f the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

Def. 51. **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.

Def. 52. **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. 53. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is not based on established medical practice in India, is a treatment experimental or unproven.

Def. 54. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited.

Def. 55. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

SECTION. 12. CLAIM RELATED INFORMATION

For any claim related query, intimation of claim and submission of claim related documents,

You can Contact us on

HDFC ERGO General Insurance Co. Ltd.
Stellar IT Park, Tower-1
5th Floor, C - 25, Sector 62
Noida -201301
Toll Free :1800 2 700 700 (Accessible from India only)
Phone (UAN) :1860 2000 700 (Local charges applicable)
Fax (UAN) : 1860 2000 600 (Local charges applicable)
Email :healthclaims@hdfcergo.com

SECTION. 13. GRIEVANCE REDRESSAL PROCEDURE

At HDFC ERGO General Insurance, we are committed to serve our customers to their satisfaction by providing fast, fair and friendly services at all times.

However, should a customer feel that our services need improvement and wish to lodge your feedback / complaint, you may:

- Call our 24X7 Toll free number 1800-2700-700 from any Landline & Mobile or 1800-226-226 from MTNL or BSNL Phone.
- For lodging a complaint online, email us to our customer service desk at care@hdfcergo.com.

After investigating the matter internally, we will send our response within a period of 10 days.

In case the resolution is likely to take longer time, we will inform you of the same through an interim reply.

Escalation Level 1
For lack of a response or if the response provided does not meet your expectation, you can write to: grievance@hdfcergo.com

After examining the matter, final response would be conveyed within a period of 15 days from the date of receipt of your complaint on this e-mail id.

Escalation Level 2
In case, you are not satisfied with the decision/resolution of the above office, or have not received any response within 15 days, you may write to: cgo@hdfcergo.com

Escalation Level 3
If after following Escalation Level 1 and 2 as stated above your issue remains unresolved, you may approach the Insurance Ombudsman for Redressal.

Contact Details of Insurance Ombudsman

Names of Ombudsman and Addresses of Ombudsmen Centres
Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C. U. Shah College, Ashram Road, **AHMEDABAD** - 380 014. Tel.: 079 - 27545441 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in
Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR** - 751 009. Tel.: 0674 - 2596455 / 2596003 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI** - 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Near Panbazar Overbridge, S. S. Road, **GUWAHATI** - 781 001 (ASSAM). Tel.: 0361 - 2132204 / 5 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
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Shri Y.R. Raigar, Secretary,
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Appendix I: Day Care Procedure

Day Care Procedures will include following Day Care Surgeries & Day Care Treatments

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
7. Revision of a tympanoplasty
8. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinusaspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations forpterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract
39. Retinal Detatchment

Operations on the skin & subcutaneous tissues

40. Incision of a pilonidal sinus
41. Other incisions of the skin and subcutaneous tissues
42. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
43. Local excision of diseased tissue of the skin and subcutaneous tissues
44. Other excisions of the skin and subcutaneous tissues
45. Simple restoration of surface continuity of the skin and subcutaneous tissues
46. Free skin transplantation, donor site
47. Free skin transplantation, recipient site
48. Revision of skin plasty
49. Other restoration and reconstruction of the skin and subcutaneous tissues
50. Chemosurgery to the skin
51. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

52. Incision, excision and destruction of diseased tissue of the tongue
53. Partial glossectomy
54. Glossectomy
55. Reconstruction of the tongue
56. Other operations on the tongue

Operations on the salivary glands & salivary ducts

57. Incision and lancing of a salivary gland and a salivary duct

58. Excision of diseased tissue of a salivary gland and a salivary duct
59. Resection of a salivary gland
60. Reconstruction of a salivary gland and a salivary duct
61. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

62. External incision and drainage in the region of the mouth, jaw and face
63. Incision of the hard and soft palate
64. Excision and destruction of diseased hard and soft palate
65. Incision, excision and destruction in the mouth
66. Plastic surgery to the floor of the mouth
67. Palatoplasty
68. Other operations in the mouth under general/spinal anesthesia

Operations on the tonsils & adenoids

69. Transoral incision and drainage of a pharyngeal abscess
70. Tonsillectomy without adenoidectomy
71. Tonsillectomy with adenoidectomy
72. Excision and destruction of a lingual tonsil
73. Other operations on the tonsils and adenoids under general/spinal anesthesia

Trauma surgery and orthopaedics

74. Incision on bone, septic and aseptic
75. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76. Suture and other operations on tendons and tendon sheath
77. Reduction of dislocation under GA
78. Arthroscopic kneeaspiration

Operations on the breast

79. Incision of the breast
80. Operations on the nipple

Operations on the digestive tract

81. Incision and excision of tissue in the perianal region
82. Surgical treatment of anal fistulas
83. Surgical treatment of haemorrhoids
84. Division of the anal sphincter (sphincterotomy)
85. Other operations on the anus
86. Ultrasound guidedaspirations
87. Sclerotherapy

Operations on the female sexual organs

88. Incision of the ovary
89. Insufflation of the Fallopian tubes
90. Other operations on the Fallopian tube
91. Dilatation of the cervical canal
92. Conisation of the uterine cervix
93. Other operations on the uterine cervix
94. Incision of the uterus (hysterotomy)
95. Therapeutic curettage
96. Culdotomy
97. Incision of the vagina
98. Local excision and destruction of diseased tissue of the vagina and the pouch ofDouglas
99. Incision of the vulva
100. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

101. Incision of the prostate
102. Transurethral excision and destruction of prostate tissue
103. Transurethral and percutaneous destruction of prostate tissue
104. Open surgical excision and destruction of prostate tissue
105. Radical prostatovesiculectomy
106. Other excision and destruction of prostate tissue
107. Operations on the seminal vesicles
108. Incision and excision of periprostatic tissue
109. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

110. Incision of the scrotum and tunica vaginalis testis
111. Operation on a testicular hydrocele
112. Excision and destruction of diseased scrotal tissue
113. Plastic reconstruction of the scrotum and tunica vaginalis testis
114. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

115. Incision of the testes
116. Excision and destruction of diseased tissue of the testes
117. Unilateral orchidectomy
118. Bilateral orchidectomy
119. Orchidopexy
120. Abdominal exploration in cryptorchidism
121. Surgical repositioning of an abdominal testis
122. Reconstruction of the testis
123. Implantation, exchange and removal of a testicular prosthesis
124. Other operations on the testis

Operations on the spermatic cord, epididymis und ductus deferens

125. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126. Excision in the area of the epididymis
127. Epididymectomy
128. Reconstruction of the spermatic cord
129. Reconstruction of the ductus deferens and epididymis
130. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

131. Operations on the foreskin
132. Local excision and destruction of diseased tissue of the penis
133. Amputation of the penis
134. Plastic reconstruction of the penis
135. Other operations on the penis

Operations on the urinary system

136. Cystoscopical removal of stones

Other Operations

137. Lithotripsy
138. Coronary angiography
139. Haemodialysis
140. Radiotherapy forCancer
141. Cancer Chemotherapy
142. Renal Biopsy
143. Bone MarrowBiopsy
144. Liver Biopsy

APPENDIX-II

Sr. No.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE	
1.	Anne French Charges	Not Payable
2.	Baby Charges (unless Specified/ indicated)	Not Payable
3.	Baby Food	Not Payable
4.	Baby Utilites Charges	Not Payable
5.	Baby Set	Not Payable
6.	Baby Bottles	Not Payable
7.	Bottle	Not Payable
8.	Brush	Not Payable
9.	Cosy Towel	Not Payable
10.	Hand Wash	Not Payable
11.	Moisturiser Paste Brush	Not Payable
12.	Powder	Not Payable
13.	Razor	Payable
14.	Towel	Not Payable
15.	Shoe Cover	Not Payable
16.	Beauty Services	Not Payable
17.	Belts/ Braces	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine

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18.	Buds	Not Payable
19.	Barber Charges	Not Payable
20.	Caps	Not Payable
21.	Cold Pack/hot Pack	Not Payable
22.	Carry Bags	Not Payable
23.	Cradle Charges	Not Payable
24.	Comb	Not Payable
25.	Disposables Razors Charges (For Site Preparations)	Payable
26.	Eau-de-cologne / Room Freshners	Not Payable
27.	Eye Pad	Not Payable
28.	Eye Sheild	Not Payable
29.	Email/ Internet Charges	Not Payable
30.	Food Charges (other Than Patient's Diet Provided By Hospital)	Not Payable
31.	Foot Cover	Not Payable
32.	Gown	Not Payable
33.	Leggings	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
34.	Laundry Charges	Not Payable
35.	Mineral Water	Not Payable
36.	Oil Charges	Not Payable
37.	Sanitary Pad	Not Payable
38.	Slippers	Not Payable
39.	Telephone Charges	Not Payable
40.	Tissue Paper	Not Payable
41.	Tooth Paste	Not Payable
42.	Tooth Brush	Not Payable
43.	Guest Services	Not Payable
44.	Bed Pan	Not Payable
45.	Bed Under Pad Charges	Not Payable
46.	Camera Cover	Not Payable
47.	Care Free	Not Payable
48.	Cliniplast	Not Payable
49.	Crepe Bandage	Not Payable/ Payable by the patient
50.	Curapore	Not Payable
51.	Diaper of Any Type	Not Payable
52.	Eyelet Collar	Not Payable
53.	Face Mask	Not Payable
54.	Flexi Mask	Not Payable
55.	Dvd, Cd Charges	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
56.	Gause Soft	Not Payable
57.	Gauze	Not Payable
58.	Hand Holder	Not Payable
59.	Hansaplast/ Adhesive Bandages	Not Payable
60.	Lactogen/ Infant Food	Not Payable
61.	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
62.	Weight Control Programs/ Supplies/ Services	Exclusion in policy unless otherwise specified
63.	Cost Of Spectacles/ Contact Lenses/ Hearing Aids Etc.,	Exclusion in policy unless otherwise specified
64.	Dental Treatment Expenses That Do Not Require Hospitalisation	Exclusion in policy unless otherwise specified
65.	Hormone Replacement Therapy	Exclusion in policy unless otherwise specified
66.	Home Visit Charges	Exclusion in policy unless otherwise specified
67.	Infertility/ Subfertility/ Assisted Conception Procedure	Exclusion in policy unless otherwise specified
68.	Obesity (including Morbid Obesity) Treatment	Exclusion in policy unless otherwise specified
69.	Psychiatric & Psychosomatic Disorders	Exclusion in policy unless otherwise specified
70.	Corrective Surgery For Refractive Error	Exclusion in policy unless otherwise specified
71.	Treatment Of Sexually Transmitted Diseases	Exclusion in policy unless otherwise specified
72.	Donor Screening Charges	Exclusion in policy unless otherwise specified
73.	Admission/Registration Charges	Exclusion in policy unless otherwise specified
74.	Hospitalisation For Evaluation/ Diagnostic Purpose	Exclusion in policy unless otherwise specified
75.	Expenses For Investigation/ Treatment Irrelevant to the Disease for which Admitted or Diagnosed	Not Payable- Exclusion in policy unless otherwise specified
76.	Any Expenses When the Patient is Diagnosed with Retro Virus + or Suffering from /hiv/ Aids etc is Detected/ Directly or Indirectly	Not payable as per HIV/AIDS exclusion
77.	Stem Cell Implantation/ Surgery	Not Payable except Bone Marrow Transplantation where covered by policy
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES	
78.	Ward And Theatre Booking Charges	Payable under OT Charges, not payable separately
79.	Arthroscopy & Endoscopy Instruments	Rental charged by the hospital payable. Purchase of Instruments not payable.
80.	Microscope Cover	Payable under OT Charges, not separately
81.	Surgical Blades,harmonic Scalpel, shaver	Payable under OT Charges, not separately

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82.	Surgical Drill	Payable under OT Charges, not separately
83.	Eye Kit	Payable under OT Charges, not separately
84.	Eye Drape	Payable under OT Charges, not separately
85.	X-ray Film	Payable under Radiology Charges, not as consumable
86.	Sputum Cup	Payable under Investigation Charges, not as consumable
87.	Boyles Apparatus Charges	Part of OT Charges, not seperately
88.	Blood Grouping And Cross Matching of Donors Samples	Part of Cost of Blood, not payable
89.	Savlon	Not Payable - Part of Dressing Charges
90.	Band Aids, Bandages, Sterlile Injections, Needles, Syringes	Not Payable - Part of Dressing Charges
91.	Cotton	Not Payable - Part of Dressing Charges
92.	Cotton Bandage	Not Payable - Part of Dressing Charges
93.	Micropore/ Surgical Tape	Not Payable- Payable by the patient when prescribed, otherwise included as Dressing Charges
94.	Blade	Not Payable
95.	Apron	Not Payable - Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
96.	Torniquet	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
97.	Ortho bundle, Gynaec Bundle	Part of Dressing Charges
98.	Urine Container	Not Payable
	ELEMENTS OF ROOM CHARGE	
99.	Luxury Tax	Actual tax levied by government is payable Part of room charge for sub limits
100.	Hvac	Part of room charge not payable separately
101.	House Keeping Charges	Part of room charge not payable separately
102.	Service Charges Where Nursing Charge also Charged	Part of room charge not payable separately
103.	Television & Air Conditioner Charges	Payable under room charges not if separately levied
104.	Surcharges	Part of room charge not payable separately
105.	Attendant Charges	Not Payable - Part of Room Charges
106.	Im Iv Injection Charges	Part of nursing charges, not payable
107.	Clean Sheet	Part of Laundry/ Housekeeping not payable separately
108.	Extra Diet of Patient (other than that which forms part of Bed charge)	Patient Diet provided by hospital is payable
109.	Blanket/ warmer Blanket	Not Payable- part of room charges
	ADMINISTRATIVE OR NON-MEDICAL CHARGES	
110.	Admission Kit	Not Payable
111.	Birth Certificate	Not Payable
112.	Blood Reservation Charges and Ante Natal Booking Charges	Not Payable
113.	Certificate Charges	Not Payable
114.	Courier Charges	Not Payable
115.	Convenyance Charges	Not Payable
116.	Diabetic Chart Charges	Not Payable
117.	Documentation Charges/ Administrative Expenses	Not Payable
118.	Discharge Procedure Charges	Not Payable
119.	Daily Chart Charges	Not Payable
120.	Entrance Pass/Visitors Pass Charges	Not Payable
121.	Expenses Related to Prescription on Discharge	To be claimed by patient under Post Hosp where admissible
122.	File Opening Charges	Not Payable
123.	Incidental Expenses/Misc. Charges (not Explained)	Not Payable
124.	Medical Certificate	Not Payable
125.	Maintainance Charges	Not Payable
126.	Medical Records	Not Payable
127.	Preparation Charges	Not Payable
128.	Photocopies Charges	Not Payable
129.	Patient Identification Band/ Name Tag	Not Payable
130.	Washing Charges	Not Payable
131.	Medicine Box	Not Payable
132.	Mortuary Charges	Payable upto 24 hrs, shifting charges not payable
133.	Medico Legal Case Charges (mlc Charges)	Not Payable
	EXTERNAL DURABLE DEVICES	
134.	Walking Aids Charges	Not Payable
135.	Bipap Machine	Not Payable
136.	Commode	Not Payable
137.	Cpap/ Capd Equipments	Device not Payable
138.	Infusion Pump - Cost	Device not Payable
139.	Oxygen Cylinder(for Usage Outside the Hospital)	Not Payable
140.	Pulseoxymeter Charges	Device not Payable
141.	Spacer	Not Payable
142.	Spirometre	Device not Payable
143.	Spo2 Probe	Device not Payable
144.	Nebulizer Kit	Device not Payable
145.	Steam Inhaler	Not Payable
146.	Armsling	Not Payable
147.	Thermometer	Not Payable (paid by patient)
148.	Cervical Collar	Not Payable
149.	Splint	Not Payable
150.	Diabetic Foot Wear	Not Payable

151.	Knee Braces (Long/ Short/ Hinged)	Not Payable
152.	Knee Immobilizer/ shoulder Immobilizer	Not Payable
153.	Lumbo Sacral Belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
154.	Nimbus Bed or Water or Air Bed Charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
155.	Ambulance Collar	Not Payable
156.	Ambulance Equipment	Not Payable
157.	Microsheild	Not Payable
158.	Abdominal Binder	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
159.	Betadine\hydrogen Peroxide\spirit\ dettol\savlon\Disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
160.	Private Nurses Charges- Special Nursing Charges	Post hospitalization nursing charges not Payable
161.	Nutrition Planning Charges - Dietician Charges - Diet Charges	Patient Diet provided by hospital is payable
162.	Alex Sugar Free	Payable -Sugar free variants of admissable medicines are not excluded
163.	Creams Powders Lotions (toileteries are not Payable, only Prescribed Medical Pharmaceuticals Payable)	Payable when prescribed
164.	Digene Gel/ Antacid Gel	Payable when prescribed
165.	Ecg Electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
166.	Gloves	Sterilized Gloves payable/ unsterilized gloves not payable
167.	HIV Kit	Payable - payable Pre operative screening
168.	Listerine/ Antiseptic Mouthwash	Payable when prescribed
169.	Lozenges	Payable when prescribed
170.	Mouth Paint	Payable when prescribed
171.	Nebulisation Kit	If used during hospitalization is payable reasonably
172.	Neosprin	Payable when prescribed
173.	Novarapid	Payable when prescribed
174.	Volini Gel/ Analgesic Gel	Payable when prescribed
175.	Zytee Gel	Payable when prescribed
176.	Vaccination Charges	Routine Vaccination not Payable/ Post Bite Vaccination Payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
177.	AHD	Not Payable - Part of Hospital's internal Cost
178.	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
179.	Scrub Solution/sterillium	Not Payable - Part of Hospital's internal Cost
	OTHERS	
180.	Vaccine Charges for Baby	Not Payable
181.	Aesthetic Treatment/ Surgery	Not Payable
182.	TPA Charges	Not Payable
183.	Visco Belt Charges	Not Payable
184.	Any Kit with no Details Mentioned [delivery Kit, Ortho kit, Recovery Kit, etc]	Not Payable
185.	Examination Gloves	Not Payable
186.	Kidney Tray	Not Payable
187.	Mask	Not Payable
188.	Ounce Glass	Not Payable
189.	Outstation Consultant's/ Surgeon's Fees	Not Payable
190.	Oxygen Mask	Not Payable
191.	Paper Gloves	Not Payable
192.	Pelvic Traction Belt	Should be payable in case of PIVD requiring tractions this is generally not reused
193.	Referal Doctor's Fees	Not Payable
194.	Accu Check (glucometery/ Strips)	Not payable pre hospitalisation or post hospitalisation/Reports and Charts required/ Device not payable
195.	Pan Can	Not Payable
196.	Sofnet	Not Payable
197.	Trolly Cover	Not Payable
198.	Urometer, Urine Jug	Not Payable
199.	Ambulance	Payable- Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
200.	Tegaderm/ Vasofix Safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
201.	Urine Bag	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
202.	Softovac	Not Payable
203.	Stockings	Essential for case like CABG etc. where it should be paid.