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Operating Clause

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

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

SECTION A. DEFINITIONS

1. Definitions applicable to the Policy

I. Standard Definitions

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

Def. 2. AYUSH HOSPITAL means an AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

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

Def. 3. AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner(s)* on day care basis without in-patient services and must comply with all the following criterion:

- i.** Having qualified registered AYUSH *Medical Practitioner (s)* in charge;
- ii.** Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 4. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

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

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

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

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

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

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

Def. 9. Day care Centre means any institution established for Day Care Treatment of Illness and / or injuries or a medical set -up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 10. Day Care Treatment/ Procedures means those 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 Hospitalization of more than 24 hours,

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

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

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

Def. 13. Disclosure of information norm means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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- Def. 14. Domiciliary Hospitalization** 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:
- the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
 - the patient takes treatment at home on account of non-availability of room in a Hospital
- Def. 15. Emergency Care** means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health.
- Def. 16. Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. 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. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).
- Def. 17. Hospital** means any institution established for In-patient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
 - has qualified nursing staff under its employment round the clock,
 - has qualified Medical Practitioner(s) in charge round the clock,
 - has a fully equipped operation theatre of its own where surgical procedures are carried out,
 - maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
- Def. 18. Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
- Def. 19. Illness/Illnesses** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment
- Acute condition:** Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/Illness/Injury which leads to full recovery
 - Chronic condition:** A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

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

Def. 20. Injury means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 21. In-patient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

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

Def. 24. Maternity Expenses means

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

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

Def. 26. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 27. Medically Necessary treatment means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 28. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice

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medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured person's and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

- Def. 29. Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
- Def. 30. Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days
- Def. 31. Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.
- Def. 32. Non Network** means any Hospital, Day Care Centre or other provider that is not part of the Network
- Def. 33. Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
- Def. 34. OPD Treatment** means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
- Def. 35. Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
- Def. 36. Pre-existing disease** means any condition, ailment, injury or disease:
- That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
 - For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
- Def. 37. Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
- Def. 38. Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:
- Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and
 - The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance company.
- Def. 39. Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India
- Def. 40. Renewal means** the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods
- Def. 41. Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses

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- Def. 42. Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of Illness/ Injury involved.
- Def. 43. Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.
- Def. 44. Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a medical practitioner.

II. Specific Definitions

- Def. 1. Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not.
- Def. 2. Age or Aged** means completed years as at the Policy Commencement Date.
- Def. 3. Aggregate Deductible:** Aggregate deductible means a cost-sharing requirement that provides that the Company will not be liable for a specified amount of the covered expenses in respect of all admissible claims made under the Policy in aggregate, and which will apply before any benefits are payable by the Company. The Aggregate Deductible does not reduce the Sum Insured.
- Def. 4. Associated Medical Expenses** means consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anaesthesia, blood, oxygen incurred during Hospitalization of the Insured Person
- Def. 5. AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- Def. 6. Bank rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
- Def. 7. Base Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for respective section during the Policy Year.
- Def. 8. Break in policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
- Def. 9. Biological attack or weapons** the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
- Def. 10. Catastrophic Event** means and includes Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood, Inundation and Earthquake
- Def. 11. Chemical attack or weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

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- Def. 12. Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule/Certificate of Insurance
- Def. 13. Coma/Comatose State** means a state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
- i. no response to external stimuli continuously for at least 96 hours;
 - ii. life support measures are necessary to sustain life; and
 - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
 - iv. The condition has to be confirmed by a specialist medical practitioner.
 - v. Coma resulting directly from alcohol or drug abuse is excluded.
- Def. 14. Coverage Period** means the Period between the Coverage effective date and the expiry date applicable to Insured Person specified in the Policy Schedule/Certificate of Insurance.
- Def. 15. EMI or EMI amount** means and includes the amount of monthly payment required to repay the principal amount of loan/credit and Interest by the Insured as set forth in the amortization chart referred to in the agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured Person prior to the date of occurrence of the Insured coverage under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured. EMI refers to the EMI or Pre EMI on the loan/credit or the Sum Insured, whichever is lower, on the date of the Insured Event
- Def. 16. Dependent child/children** means Your children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households.
- Def. 17. Family Floater** means a Policy described as such in the Policy Schedule where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date on floater Sum Insured basis.
- Def. 18. Life threatening situation** shall mean a serious medical condition or symptom resulting from Injury or Illness which is not pre-existing disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.
- Def. 19. Insured Person** means You and the persons named in the Policy Schedule who are insured under the Policy.
- Def. 20. Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
- Def. 21. Medical Consultation** is a procedure where a Medical Practitioner reviews an Insured Person's medical history, medically examines the Insured Person and makes recommendations as to care and treatment.
- Def. 22. Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to

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meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence;

- Def. 23. Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;
- Def. 24. Mental Health Nurse** means a person with a diploma or degree in general nursing or diploma or degree in psychiatric nursing recognised by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State
- Def. 25. Non-Medical Expenses:** are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergo.com
- Def. 26. Nuclear attack** means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
- Def. 27. Period of Insurance** means the period between the Coverage Commencement Date and the Expiry Date specified in the Policy Schedule/Certificate of Insurance under the Policy with the Company under which Insured Person is covered.
- Def. 28. Policy means** Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), and the Policy Schedule (as the same may be amended from time to time).
- Def. 29. Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule. For Insured Person it means Period of Insurance as specified in the Certificate of Insurance or Endorsement
- Def. 30. Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued
- Def. 31. Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to (Schedule of coverage), including any Annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
- Def. 32. Policy Year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

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- Def. 33. Preventive Health Check-up:** Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.
- Def. 34. Second Medical Opinion** means a procedure where by upon request of Insured Person, an independent Medical Practitioner reviews and opines on treating Medical Practitioner's recommendation as to care and treatment of Insured Person by reviewing Insured Person's medical status and history
- Def. 35. Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.
- Def. 36. Sum Insured** means the aggregate limit of indemnity consisting of the Base Sum Insured, Cumulative Bonus, Restore Benefit (provided that these optional covers are in force for the Insured Person) as specified in the Schedule of Coverage on the Policy Schedule/Certificate, for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year
- Def. 37. Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit
- Def. 38. Time Deductible** means a cost sharing requirement under a health insurance Policy that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer. A Time Deductible does not reduce the Sum Insured
- Def. 39. We/Our/Us/Insurer/Company** means the HDFC ERGO General Insurance Company Limited
- Def. 40. You/Your** means the Insured Person named in the Policy Schedule who is insured under the Policy

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

1. Cancer of specified severity

A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

The following are excluded:

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

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2. Open Chest CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- II. The following are excluded:
 - a. Angioplasty and/or any other intra-arterial procedures

3. Myocardial Infarction (First Heart Attack of specified severity)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
 - a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
 - b. New characteristic electrocardiogram changes
 - c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. The following are excluded:
 - a. Other acute Coronary Syndromes
 - b. Any type of angina pectoris
 - c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. Kidney failure requiring regular dialysis

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

5. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are excluded:

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

6. Multiple Sclerosis with persisting symptoms

- I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- II. Neurological damage due to SLE is excluded.

7. Permanent Paralysis of Limbs

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

8. Stroke resulting in permanent symptoms

- I. Any cerebrovascular incident producing permanent neurological sequelae.
 - a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.
 - b. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
- II. The following are excluded:
 - a. Transient ischemic attacks (TIA)
 - b. Traumatic injury of the brain
 - c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

SECTION B. COVERAGES

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

I. Hospitalization Expenses

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

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

a. In Patient Treatment

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

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

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Proportionate Deduction

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

b. Pre-Hospitalization Expenses

We will pay for the Pre-Hospitalization Medical Expenses incurred during the number of days as specified in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance immediately before Hospitalization of an Insured Person.

Conditions:

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

c. Post-Hospitalization Expenses

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

Conditions:

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

d. Domiciliary Hospitalization

We will pay the Medical Expenses as specified in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance incurred on Domiciliary Hospitalization of the Insured Person prescribed by treating Medical Practitioner.

e. Organ Donor Expenses

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

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

f. Day Care Treatment

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

- All day care procedures are covered under this benefit.

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g. Road Ambulance Cover

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

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

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

Insuring Clause

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

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

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

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

a. Alternative Treatment

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

Note : Alternative Treatment is no longer an optional cover. Basis CIR. Ref. IRDAI/HLT/CIR/GDL/31/01/2024 issued by IRDAI, all Insured Person shall be covered by default for In-patient care expenses under this cover upto Sum Insured of Section B.I.a. (Hospitalization Expenses).

Details mentioned in the Policy Schedule against this cover shall be superceded by the above wordings.

b. Preventive Health Check-Up

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

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ii. Other terms and Conditions applicable to this Coverage

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

c. Co-Payment

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

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

- i.** We will pay expenses incurred towards Second Medical Opinion availed from Medical Practitioner in respect of Critical Illnesses (CI) listed below through our Network Provider.
- ii.** The coverage under this benefit shall be available as per the below conditions:
 - One Second Medical Opinion from the below listed Critical Illness per Insured Person per Policy Year shall be available for both individual and floater policies.

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

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

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e. Restore Benefit

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

- i. This Benefit shall be applied for the number of times as mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.
- ii. The Base Sum Insured restoration under the Restore Benefit would be triggered only upon complete or partial utilization of the Base Sum Insured, or complete or partial utilization of Restore benefit as may be applicable by the way of claims admitted under the Policy. Restore benefit shall be available for subsequent claims thereafter in the Policy Year, for the Insured Person.
- iii. In case of a family floater policy, the Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.
- iv. Single claim in a Policy Year cannot exceed the Base Sum Insured and Cumulative Bonus (if applicable).

Illustration :

Base Sum Insured : 5 Lacs

Cumulative Bonus : 2.5 Lacs

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

*if opted

f. Cumulative Bonus

- i. On each continuous completion of a Policy Year of the Coverage with Us, We will apply percentage of Base Sum Insured irrespective of any claims and shall be available under the Renewed Policy as specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance under expiring policy year as Cumulative Bonus in the Coverage provided that;
 - a) Cumulative Bonus can be accumulated upto the limit mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
 - b) Cumulative Bonus applied will be applicable only to Insured Person(s) covered under the expiring policy year and who continue to remain insured on Renewal.

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- c) In policies with a 2/3 year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.
- d) Portability/migration benefit will be offered to the extent of sum of previous sum insured and accrued Cumulative bonus, portability/migration benefit shall not apply to any other additional increased Sum Insured.
- e) The applicable Cumulative Bonus shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy

g. Recovery Benefit

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

h. Air Ambulance Cover

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

i. Pre-Existing Disease Waiting period Modification Option

- i. On availing this option, Waiting Periods listed under Section C. I.i shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
- ii. All other terms and Conditions of the Policy shall remain unaltered.

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

- i. On availing this option, Waiting Periods listed under Section C. I.ii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
- ii. All other terms and Conditions of the Policy shall remain unaltered.

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

- i. On availing this option, Waiting Periods listed under Section C. I.iii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
- ii. All other terms and Conditions of the Policy shall remain unaltered

l. Pre and Post Hospitalisation Expenses Days Modification Option

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

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m. Room Rent Restriction

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

n. Road Ambulance Cover Modification Option

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

II. EMI Hospitalization

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

Note pertaining specifically to AYUSH Treatments only:

EMI Hospitalization also includes coverage for In-patient care AYUSH treatments taken in an AYUSH Hospital

Conditions applicable to EMI Hospitalization benefit

- a. The maximum worth of claim payout in a Policy Year shall not exceed the number of times/amount as mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance of Lumpsum Sum Insured chosen.
- b. Fraction of Lumpsum Sum Insured chosen to be paid every time claim triggers shall be as specified in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance
- c. Exclusions & waiting periods applicable to this benefit by default shall be as per Section C. and in case modification option is exercised the Exclusions & waiting periods applicable shall be as specified in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance
- d. Coverage for this section shall be on individual basis in case more than one member is part of the policy

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

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

a. Maternity coverage

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

b. Cumulative Bonus for EMI Hospitalization benefit

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

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

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- b)** Cumulative Bonus applied will be applicable only to Insured Person(s) covered under the expiring policy year and who continue to remain insured on Renewal.
 - c)** In policies with a 2/3 year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.
 - d)** Portability/migration benefit will be offered to the extent of sum of previous sum insured and accrued Cumulative bonus, portability/migration benefit shall not apply to any other additional increased Sum Insured.
 - e)** The applicable Cumulative Bonus shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy
- c. Pre-Existing Disease** Waiting period Modification Option
 - i.** On availing this option, Waiting Periods listed under Section C. I.i shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
 - ii.** All other terms and Conditions of the Policy shall remain unaltered.
- d. Specified Disease/Procedure** (Specific Illness) Waiting period Modification Option
 - i.** On availing this option, Waiting Periods listed under Section C. I.ii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
 - ii.** All other terms and Conditions of the Policy shall remain unaltered.
- e. General Waiting Period** (30-day waiting period) Modification Option
 - i.** On availing this option, Waiting Periods listed under Section C. I.iii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.
 - ii.** All other terms and Conditions of the Policy shall remain unaltered

IV. Wellness Services

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

Note for all Insured persons :

- i.** Consultation must not be considered a substitute to medical opinion or advice nor shall the same be pursued over a medical advice or opinion given by treating Medical Practitioner
- ii.** By seeking Tele/Video/Physical consultation under this benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
- iii.** The Insured Person is free to choose whether or not to obtain the Tele/Video/Physical consultation, and if obtained then whether or not to act on it in whole or in part.
- iv.** Consultations/benefit programs can be booked digitally & any unutilised consultations shall lapse & will not be carried forward. Information regarding limits for all the below benefits shall be available on the digital platform of our empanelled Service Provider.
- v.** Tele/Video/Physical consultation under this benefit shall not be valid for any medico-legal purposes.
- vi.** We do not represent correctness of Consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice,

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prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner

a. Anytime Doc-on-Call

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

b. Doctor Consultations

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

c. Diagnostic Tests

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

d. Base Diabetes Management Program

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

e. Tele / Video Consultations

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

f. Concierge for 24x7 Services

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

g. Nutritionist Consultation & Diet Planning

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

SECTION C. EXCLUSIONS AND WAITING PERIODS

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

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

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

I. Standard Waiting Periods

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

i) Pre-existing Diseases waiting period: Code – Excl01

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

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Schedule of Coverage on the Policy Schedule/Certificate of Insurance after the date of inception of the policy with insurer.

- b)** In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.
- c)** If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- d)** Coverage under the Policy after the expiry of number of months of continuous coverage as specified in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance after the date of inception of the policy with insurer for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

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

Illnesses

Internal Congenital diseases	Non infective Arthritis	Pilonidal sinus
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g. Kidney stone, Urinary Bladder Stone	Benign tumors, cysts, nodules, polyps including breast lumps
Pancreatitis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors
Cataract	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Osteoarthritis and osteoporosis	Fibroids (fibromyoma)	Benign Hyperplasia of Prostate

Surgical Procedures

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

iii) General Waiting Period (30-day waiting period): Code – Excl03

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

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

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

II. Standard Permanent Exclusions

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

i. Investigation & Evaluation: Code Excl04

- a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
- b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

- a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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- b.** Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
 - iii. Obesity/Weight control: Code – Excl06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 - a.** Surgery to be conducted is upon the advice of the doctor
 - b.** The surgery/procedure conducted should be supported by clinical protocols
 - c.** The member has to be 18 years of age or older and
 - d.** Body Mass Index (BMI)
 - a.** Greater than or equal to 40 or,
 - b.** Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - 1.** Obesity related cardiomyopathy
 - 2.** coronary heart disease
 - 3.** severe sleep apnoea
 - 4.** uncontrolled type2 diabetes
- iv. Change-of-Gender treatments: Code – Excl07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- v. Cosmetic or plastic surgery: Code – Excl08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- vi. Hazardous or Adventure Sports: Code – Excl09:** Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.
- vii. Breach of Law: Code – Excl10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- viii. Excluded Providers: Code – Excl11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.
- ix.** Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12
- x.** Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code – Excl13
- xi.** Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. Code – Excl14
- xii.** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries. Code – Excl15

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- xiii. Unproven Treatments:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. Code – Excl16
- xiv. Sterility and Infertility: Code – Excl17:** Expenses related to sterility and infertility. This includes:
 - a.** Any type of contraception, sterilization
 - b.** Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c.** Gestational Surrogacy
 - d.** Reversal of sterilization
- xv. Maternity: Code – Excl18**
 - a.** Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b.** Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.

III. Specific Permanent Exclusions

- i.** War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical or Biological attack or weapons, radiation of any kind.
- ii.** Aggregate Deductible - We are not liable for Claims/Claim amount falling within Aggregate Deductible limit if applicable and as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.
- iii.** Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.
- iv.** Any Insured Person's participation or involvement in naval, military or air force operation.
- v.** Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
- vi.** Congenital external diseases, defects or anomalies,
- vii.** Stem cell harvesting.
- viii.** Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
- ix.** Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
- x.** Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
- xi.** Vaccination including inoculation and immunisations (Except post Animal bite treatment),
- xii.** Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.

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- xiii.** OPD treatment,
- xiv.** The provision or fitting of hearing aids, spectacles or contact lenses.
- xv.** Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, Optometric therapy.
- xvi.** Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.
- xvii.** Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively). prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses is attached and also available on www.hdfcergo.com
- xviii.** Any Non allopathic treatment except to the extent of coverage provided for under 'Alternative Treatment' cover and 'EMI Hospitalization' Section.

SECTION D. GENERAL CONDITIONS

I. Standard General Conditions

1. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any Material Fact by the Policyholder.

2. Condition Precedent to Admission of Liability

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

3. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Multiple Policies

- i.** In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
- ii.** Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / policies even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.
- iii.** If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

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- iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

5. Moratorium Period

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

6. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance Policy:

- a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of Material fact are within the knowledge of the Insurer.

7. Free look period

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

The Insured Person shall be allowed Free Look period of 30 days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

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- ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

8. Migration

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

9. Portability

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

10. Cancellation

- i. The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.
- ii. Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.
- iii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.
- iv. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s
- v. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

II. Refund of Policy premium in case of death of Insured Person/s

Policy premium shall be refunded proportionately for the deceased insured person, for the unexpired period in case of death of any Insured Person/s

11. Premium Payment in Instalments

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

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

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

- ii. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received). The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.
- iii. No interest will be charged If the instalment premium is not paid on due date.
- iv. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
- v. In the event of a claim, all subsequent premium installments shall immediately become due and payable.
- vi. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

12. Instalment premium payment through Auto Debit/ECS Facility

- i. If Option of Premium payment by instalment is opted through auto Debit/ECS facility, Electronic Clearing Service (ECS) Mandate form needs to be completely filled & signed by the Insured Person.
- ii. The Premium amount which would be auto debited & frequency of instalment should be duly filled in the ECS Mandate form.
- iii. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
- iv. The Company should be informed at least 15 days prior to the due date of instalment premium if the Insured Person wishes to discontinue the ECS facility.
- v. Non-payment of premium on due date as opted by the Insured Person in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

13. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

14. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of Renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the Policy has been maintained without a break.

15. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

16. Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the Bank Rate.

17. Renewal of Policy:

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

- i. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.
- ii. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
- iii. No loading shall apply on renewals based on individual claims experience
- iv. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.
- v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

18. Redressal of Grievance

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

First Point of Contact	Call us at 022 6158 2020 / 022 6234 6234 / www.hdfcergo.com
Level 1	For lack of a response or if the response provided does not meet your expectation, you can: 1. Write to The Complaints & Grievance Cell (C&G Cell) HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra

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

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

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

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://bimabharosa.irdai.gov.in>

III. Specific General Conditions

1. Non - Disclosure or Misrepresentation

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

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- ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing Diseases subject to your prior consent;
 - a) Permanently exclude the disease/condition and continue with the Policy
 - b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
 - c) Levy underwriting loading from the first year of issuance of Policy or renewal, whichever is later.

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

2. Geography

This Policy only covers Medical Treatment taken within India.

3. Assignment

Assignment Clause: It is hereby declared and agreed for loan linked customers (wherever applicable) that :

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

4. Loadings

- i. We may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.
- ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each Insured Person
- iii. Loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum Insured. We will not apply any additional loading on Your Policy premium at Renewal based on claim experience in Your Policy.

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- iv. We will inform You about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the Policy only on Your acceptance within 15 days of the receipt of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

5. Grace Period

- i. A Grace Period of 30 days is available for Renewal of the Coverage. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.
- ii. For Renewal received after completion of Grace Period, the Coverage would be considered as fresh without any Renewal benefits
- iii. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).
- iv. For Policies on instalment basis, Grace Period is available as given below.

Instalment Premium Option	Grace Period applicable
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

6. Endorsements

The following endorsements are permissible during the Policy Period:

Non-Financial Endorsements – which do not affect the premium

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

Financial Endorsements – which result in alteration in premium

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

The Policyholder/Insured Person shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of Insured person.

7. Communication & Notice

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

SECTION E. OTHER TERMS & CONDITIONS

I. Claims Procedure

1. Notification of a Claim

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

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	4. The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.	
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the Insured person(s) iii. Nature of disease/Illness/Injury iv. Name and address of the attending Medical Practitioner/Hospital v. Date of admission & probable date of discharge vi. Approximate Claim Expenses	Not Applicable
	Any other relevant information as required	
Process for pre-authorization	On receipt of duly filled pre authorization form and other details, We may; <ul style="list-style-type: none"> Issue the authorization letter specifying the sanctioned amount, limitation, and non-payable items, if applicable Or Reject the request for pre-authorization specifying reasons for the rejection. 	Not Applicable
List of Claim documents	Not Applicable	As enlisted below
Condonation of Delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control	

2. List of documents for Reimbursement Claims

- i. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by Hospital).
- ii. Government approved Photo ID & Age Proof
- iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
- iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of Hospitalization in any non-network hospital of HDFC ERGO General Insurance Limited or certificate from Hospital authorities providing facilities available including number of beds.
- v. Discharge Card / Day Care Summary / Transfer Summary

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- vi.** Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded
- vii.** Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
- viii.** All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization.
- ix.** All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre
- x.** All medicine / pharmacy bills along with prescription by Medical Practitioner
- xi.** MLC / FIR Copy – in Accidental cases only
- xii.** History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.
- xiii.** Copy of Death Summary and copy of Death Certificate (in death claims only)
- xiv.** Pre and Post-Operative Imaging reports
- xv.** Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).
- xvi.** Invoice for Vaccination and payment receipt
- xvii.** KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Claimant carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Claimant ***
- xviii.** Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)
- xix.** Settlement letter(s), copy (-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

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

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

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

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

- i.** The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
- ii.** In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the Bank Rate.

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- iii. If requested by Us, at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
- iv. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim
- v. Claim payment & process for Section B. III & IV EMI Hospitalization
 - For Credit Linked Policies: Claim will be paid to Financier. In case EMI coverage taken differs from the EMI amount, following three scenarios can happen:
 1. EMI amount is more than actual EMI – Policy will pay entire amount to financier and residual amount after paying EMI will be adjusted against principle amount.
 2. EMI amount is less than actual EMI – Policy will pay entire amount to financier.
 3. EMI amount is more than actual EMI and loan gets foreclosed with EMI payment– Policy will pay entire amount to financier and residual amount after paying EMI will be paid to the Insured person/nominee as loan has got repaid with the EMI amount.
 - For Non Credit Linked Policies – Claims will be paid to Insured person / nominee.
- vi. In case of Employer – Employee policies, the claims of individual persons insured may be processed through the master policyholder. Further in case of Non employer - employee cases, the master policyholder may facilitate the settlement of the claim to the insured however the insurer is totally responsible to pay claim in the name of the insured person.

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

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

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Ombudsman Details

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

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

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Office Details	Jurisdiction of Office Union Territory, District)
<p>Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in</p>	
<p>DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in</p>	<p>Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.</p>
<p>GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in</p>	<p>Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.</p>
<p>HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in</p>	<p>Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.</p>
<p>JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in</p>	<p>Rajasthan.</p>
<p>KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in</p>	<p>Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.</p>
<p>KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue,</p>	<p>West Bengal, Sikkim, Andaman & Nicobar Islands.</p>

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Office Details	Jurisdiction of Office (Union Territory, District)
<p>Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in</p>	
<p>LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in</p>	<p>Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareilly, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.</p>
<p>MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in</p>	<p>List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.</p>
<p>NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in</p>	<p>State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>
<p>PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in</p>	<p>Bihar, Jharkhand.</p>
<p>PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in</p>	<p>State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region</p>
<p>THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg,</p>	<p>Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."</p>

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Office Details	Jurisdiction of Office Union Territory, District)
Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	

Annexure I

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

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS

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20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLEY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY

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

S. No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS

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11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

S. No.	Item
1	HAIR REMOVAL CREAM

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2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

S. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES



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10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG