HDFC ERGO General Insurance Company Limited

Policy Wording

Saral Suraksha Bima, HDFC ERGO

Table of Contents

HDFC ERGO General Insurance Company Limited

Policy Wording

Saral Suraksha Bima, HDFC ERGO

PREAMBLE

This Policy is a contract of insurance issued by HDFC ERGO General Insurance (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the Proposal Form by the proposer and is subject to receipt of the requisite premium.

OPERATIVE CLAUSE

Any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured and Cumulative Bonus (if any) specified in the Schedule.

SECTION A. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and third gender and references to any statutory enactment includes subsequent changes to the same.

A.1. Standard Definitions

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

Def. 2. **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 centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered

AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion

i. Having qualified registered AYUSH *Medical Practitioner* (s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

Def. 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 person 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 Company's liability under the Policy is conditional upon.

Def. 6. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 7. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs 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. 8. **Disclosure to information norm:** 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.

Def. 9. **Emergency Care** means management for an 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. 10. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received

Def. 11. **Hospital** means any institution established for in-patient care and day care treatment of disease/ 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

Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;

ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;

iii. has qualified medical practitioner (s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out

v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

Def. 12. **Hospitalisation** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

Def. 13. **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. 14. **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. 15. **Insured Person** means person(s) named in the schedule of the Policy.

Def. 16. **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. 17. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Def. 18. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 19. **Medical Expenses** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Def. 20. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

Def. 21. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or

part of a stay in hospital which

i. is required for the medical management of injury suffered by the insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner;

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 22. **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. 23. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

Def. 24. **Non- Network Provider** means any hospital that is not part of the network.

Def. 25. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

Def. 26. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Def. 1. **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. 2. **Pre-Existing Disease** means any condition, ailment, injury or disease:

a) 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

Def. 27. 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.

A.2. Specific Definitions

Def. 1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy

Def. 2. **AYUSH Treatment** refers to medical and/or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

Def. 3. **Break in policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

Def. 4. **Family** consists of the proposer and any one or more of the family members as mentioned below:

(i) legally wedded spouse.

(ii) Parents and Parents-in-law.

(iii) dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

Def. 5. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

Def. 6. **Policy period** means period of one policy year for which the Policy is issued.

Def. 7. **Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium

Def. 8. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy

Def. 9. **Renewal:** 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. 10. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Def. 11. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person.

Def. 12. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

SECTION B. BENEFITS

B.1. **COVERAGE**:

1 **Base Covers:** The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

a) **Death**: The Company shall pay the benefit equal to 100% of Sum Insured, specified in the Policy Schedule, on death of the Insured Person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of Insured Person following an accident, if after the payment of accidental death claim, it is found that the Insured Person has survived the accident, then the policyholder has to refund the payment back to the Company in consideration of the obligatory guarantee as provided during the claim.

b) **Permanent Total Disablement:** The Company shall pay the benefit equal to 100% of Sum

Insured, specified in the policy schedule, if an Insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or

b) Physical separation or loss of use of both hands or feet or

c) Physical separation or loss of use of one hand and one foot or

d) loss of sight of one eye and Physical separation or loss of use of hand or foot

e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

c) Permanent Partial Disablement:

The Company shall pay the following percentage of Sum Insured, specified in the Policy Schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

	Loss Covered	**Percentage of Sum Insured**
1.	Loss of Use/ Physical Separation: One entire hand One entire foot Loss of Sight of one eye Loss of toes – all Great both phalanges Great – one phalanx Other than great if more than one toe lost	 50% 50% 50% 20% 5% 2% 1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%
4.	Loss of four fingers and thumb of one hand	40%
5.	Loss of four fingers	35%
6.	Loss of thumb - both phalanges - one phalanx	 25% 10%
7.	Loss of Index finger- three phalanges two phalanges one phalanx	 10% 8% 4%
8.	Loss of middle finger – three phalanges	 6%

	two phalanges one phalanx	4% 2%
9.	Loss of ring finger - three phalanges two phalanges one phalanx	 5% 4% 2%
10.	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11.	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 3% 2%
12.	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the policyholder.

Note:

a) The base Sum Insured chosen and Cumulative Bonus, if any, is applicable cumulatively for all the three covers specified under B.1.1(a), B.1.1(b) and B.1.1(c) above i.e., there is a single Sum Insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.

b) If the accident occurs during the Policy Period, benefits covered under B.1.1(a), B.1.1(b) and B.1.1(c) above are payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of Policy Period, but within 12 months from the date of Accident.

2. **Optional Covers:** The covers listed below are optional benefits and shall be available to Insured Persons in accordance with the terms set out in the Policy, if the listed cover is opted.

a) Temporary Total Disablement:

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of the Accident (Temporary Total Disablement), the Company shall pay the benefit as specified in the Policy Schedule, till the time the Insured Person is able to return to work, provided that:

(i) The period of temporary total disablement shall exceed four consecutive weeks from the date of Accident, however, the benefit shall be reckoned from the date of Accident and shall be payable for the entire duration of disablement.

(ii) the compensation payable under this benefit mentioned under Section B.1.2(a) shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Sum Insured.

(iii) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.

(iv) The compensation shall be paid by the Company at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period

(v) During the course of payment under this benefit, the Company shall have right to call for a certification from an independent medical practitioner with regard to the continuity of temporary total disability specified under this section.

(vi) The insured shall notify the Company immediately on resuming to his occupation/employment. Where it is found that the insured resumed to his occupation/employment without notifying to the Company and received the compensation under this cover, the company shall have right to claim the recovery of such benefit paid.

Note: For the purpose of this benefit, "week" is a period of seven consecutive calendar days.

b) Hospitalisation Expenses due to Accident: The Company shall indemnify medical expenses incurred for hospitalisation arising due to Accident during the Policy Period, up to the limit of 10% of the base Sum Insured, specified in the Policy Schedule.

The hospitalisation expenses shall cover the following:

i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home,

ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.

iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.

(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day.)

iv. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses

v. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure carried out to treat the accidental injury covered under the policy

vi. Expenses incurred on hospitalization due to accident, under AYUSH (as defined in IRDAI

(Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following other expenses necessitated due to injury shall also be covered under the optional cover specified under Section B.1- 2(b):

i. Dental treatment.

ii. Plastic surgery.

iii. All the day care treatments.

iv. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

Note: The expenses that are not covered under the section B.1- 2(b) are placed under List-I of Annexure-B. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-B respectively.

Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to Accidental In-patient care AYUSH treatment sustained due to an accident are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. However, any medical expense other than Accidental In-patient care AYUSH treatment expenses are not covered under this policy.

c) Education Grant:

Following an admissible claim of the Insured Person under the policy towards Death or Permanent Total Disability of the Insured Person, the Company shall pay a one-time educational grant of 10% of the Base Sum insured (specified in the policy schedule), per child to all dependent children of the Insured provided that:

a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.

b. Age of the child or children as the case shall not be more than 25 completed years.

Note:

i. The benefits payable under each of the optional covers B.1.2(a), B.1- 2(b) and B.1.2(c) are independent and over and above the base Sum Insured.

ii. Claim admissibility under the optional covers "Temporary total disablement" and "hospitalization due to accident" is independent of claim admissibility under the base covers.

B.2. CUMULATIVE BONUS:

On Renewal of this Policy with the Company without a break, a sum equal to 5% of the Base Sum Insured of the expiring Policy maximum upto 50% shall be provided as CB irrespective of any claims maximum upto 50% and shall be available under the Renewed Policy subject to the

following conditions:

Notes:

a. The maximum CB will not exceed 50% of the Basic Sum Insured in any Policy Year.

b. In case where the Policy is on individual basis as specified in the Policy Schedule, the CB shall be added and available individually to the Insured Person.

c. In case where the Policy is on floater basis, the CB shall be added and available to the family on floater basis.

d. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

e. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.

f. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

g. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

h. If the Sum Insured under the Policy has been increased at the time of Renewal, the CB shall be calculated on the Sum Insured of the last completed Policy Year.

i. If the Policy Period is of two/three years, any CB that has accrued for the first/second Policy Year shall be credited post completion of each Policy Year.

j. New Insured Person added to the Policy during subsequent Renewals will be eligible for CB as per their Renewal terms.

CB shall be available only if the Cover is specified to be applicable in the Policy Schedule

SECTION C. EXCLUSIONS

C.1. Specific Exclusions (applicable to all sections of the policy)

The Company shall not be liable to make any payments under this policy in respect of:

(i) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

(ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person

a. from intentional self-injury unless in self-defence or to save life, suicide or attempted suicide;

b. whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.

c. whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.

[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]

d. arising or resulting from the Insured Person committing any breach of law with criminal intent.

(iii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person 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.

(iv) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:

A. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.

B. Nuclear weapons material

C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

D. Nuclear, chemical and biological terrorism

(v) Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

C.2. Standard Exclusions applicable only to section B.1-2(b) "Hospitalisation Expenses due to Accident"

The Company shall not be liable to make any payments under this policy in respect of any expenses incurred by the Insured Person in connection with or in respect of:

i. Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

ii. 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)

C.3. Standard Exclusions applicable only to section B.1-2(b) "Hospitalisation Expenses due to Accident"

i. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization.

ii. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

iii. Treatment taken outside the geographical limits of India.

iv. All expenses listed in Annexure-B (List I) of the Policy.

SECTION D. GENERAL TERMS AND CONDITIONS

D.1. Stanadard General Terms & 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.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

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 (Applicable to covers which offer fixed benefits)

In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

5. Multiple policies (Applicable for Section B.1- 2(b)- Hospitalisation Expenses due to Accident)

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

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

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

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

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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a 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 policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

7. Cancellation

a. 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.

b. 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.

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

d. 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

e. 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.

8. Nomination

The Insured Person 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.

9. Renewal of the 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.

a) 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.

b) 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.

c) No loading shall apply on renewals based on individual claims experience

d) 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.

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

10. Possibility of revision of the premium rates

The company, with prior approval of IRDAI, may revise or modify the premium rates.

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, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

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

Options	Instalment Premium Option	Grace Period applicable
Option 1	Multi-Year / Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	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).

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 instalments shall immediately become due and payable.

vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

12. Free Look Period

The Free Look Period will be applicable on the new policy and not on renewals

1. The insured will be allowed a period of thirty days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

a) 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;

b) where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or;

c) where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

13. Grievance Redressal Procedure

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

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

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

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

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

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

D.2. Specific General Terms & Conditions

1. Material Change

The Insured Person shall immediately notify the Company in writing of any change in his business or occupation or physical defect or infirmity with which he has become affected since the payment of last preceding premium.

2. Automatic Termination of Insurance

This policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

3. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

4. Territorial Limit

The coverage is worldwide except for the optional cover "Hospitalization expenses due to accident".

The coverage of optional cover "Hospitalization expenses due to accident", is limited to medical treatment taken in India only.

5. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

6. 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.

7. Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

SECTION E. OTHER TERMS AND CONDITIONS

E.1. CLAIM PROCEDURE

1. Notification of claim

i. Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 30 days of its happening.

ii. Claims for insurance benefits must be submitted to the Company not later than one (1) month after the completion of the treatment or after transportation of the mortal remains/ burial in the event of Death.

iii. If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency, the company shall be informed within 24 hours of the admission of the insured person in Hospital.

Note: The Company will examine and relax the time limit mentioned herein above depending upon the merits of the case.

2. Documents to be submitted:

2.1. Basic documents required for All claims

- **i.** Duly completed claim form
- **ii.** Photo Identity Proof of the insured person
- **iii.** Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required as per the circumstance of the Accident) duly attested by the concerned Police Station
- **iv.** Copy of Medico Legal Certificate (wherever it is required as per the circumstance of the Accident) duly attested by the concerned Hospital
- **v.** Any other relevant document required by the Company for assessment of the claim

2.2. Documents required in case of Death covered under Section 4.1(a)

- **i.** Death certificate;
- **ii.** Post Mortem Report (if conducted);
- **iii.** Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.

2.3. Documents required in case of Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD), covered under Sections B.1.1(b) and B.1.1(c)

- **i.** Original treating Medical Practitioner's certificate describing the disablement
- **ii.** Original Discharge summary from the Hospital
- **iii.** Disability certificate issued by treating Medical Practitioner
- **iv.** Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable.

2.4. Documents required in case of Temporary Total Disablement (TTD), covered under Section 4.2(a)

- **i.** Original treating Medical Practitioner's certificate confirming the disability
- **ii.** Original Discharge summary from the Hospital
- **iii.** Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable
- **iv.** Leave/Absence Certificate from Employer (If Employed)
- **v.** Medical Practitioner's certificate confirming the Injury and advising rest/ unfit to work for specified number of days
- **vi.** Fitness Certificate issued by the treating doctor.

2.5. Documents required for coverage under Section B.1- 2(b)- Hospitalisation Expenses due to Accident:

vi. Discharge Summary from The Hospital

vii. Medical & Investigation reports

viii. Prescriptions, and consultation papers of the treatment

ix. Any other medical, investigation reports, as applicable

2.6. Documents required for coverage under Section B.1- 2(c)- Education Grant:

x. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate.

xi. Photo Identity Proof of Child

xii. Age proof of Child

xiii. Bonafide Certificate issued by the educational institution confirming that he/she is a full time student of the institution

3. Claim Settlement

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 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.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the Financial Year in which claim has fallen due)

4. Payment of Claim

All claims under the policy shall be payable in Indian currency only

E.2. CLAIM RELATED INFORMATION

For any claim related query, intimation of claim and submission of claim related documents, insured person may contact the company through:

i. Website: www.hdfcergo.com

i. Contact no: 022 6234 6234 / 0120 6234 6234

ii. Contact Details for Senior Citizen: seniorcitizen@hdfcergo.com

iii. E-mail: care@hdfcergo.com

iv. Courier :

HDFC ERGO General Insurance Co. Ltd.

Stellar IT Park, Tower-1

5th Floor, C - 25, Sector 62

Noida – 0120 398 8360

TABLE OF BENEFITS

Name	Saral Suraksha Bima, HDFC ERGO
Product Type	Individual
Category of Cover	All the covers are benefit based except the optional cover "Hospitalisation Expenses due to Accident" which is indemnity based.
Sum insured	On Individual basis – SI shall apply to each individual family member
Policy Period	1 year
Base covers	**i.** Death **ii.** Permanent total disablement **iii.** Permanent partial disablement
Optional covers	**i.** Temporary total disablement **ii.** Hospitalisation Expenses due to Accident **iii.** Education grant
Cumulative bonus	On Renewal 5% of the Basic Sum Insured maximum upto 50% post completion of each policy year irrespective of claims.

Annexure-A

Ombudsman Details

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

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD **Office of the Insurance Ombudsman,** Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU **Office of the Insurance Ombudsman,** Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL **Office of the Insurance Ombudsman,** 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR **Office of the Insurance Ombudsman,** 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH **Office Of The Insurance Ombudsman,** 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, Sonepat 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. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).

Office Details	Jurisdiction of Office Union Territory, District)
DELHI **Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI **Office of the Insurance Ombudsman,** Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD **Office of the Insurance Ombudsman,** 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR **Office of the Insurance Ombudsman,** Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI **Office of the Insurance Ombudsman,** 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	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA **Office of the Insurance Ombudsman,** Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.

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

Office Details	Jurisdiction of Office Union Territory, District)
THANE **Office of the Insurance Ombudsman,** 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

Annexure-B

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING

41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY

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

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

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

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

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS

11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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