my: health Koti Suraksha

Contents

Section A – Definitions

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

I. Standard Definition applicable to Policy

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

Def. 2. **Any one illness** means continuous period of **Illness** and includes relapse within 45 days from the date of last consultation with the **Hospital**/Nursing Home where treatment was taken

Def. 3. **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. 4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner*(s) on day care basis without in-patient services and must comply with all the following criterion:

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

Def. 5. **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. 6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon

Def. 7. **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. 8. **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. 9. **Cumulative Bonus**means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 10. **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. 11. **Day Care Treatment/ Procedures**means those medicaltreatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a **Hospital**/**Day Care Centre** in less than 24 hours because of technological advancement, and
ii) which would have otherwise required **Hospitalization** of more than 24 hours,

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

Def. 12. **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. 13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 14. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 15. **Domiciliary Hospitalization** means medical treatment for an **Illness**/disease/**Injury** whichin the normal course would require care and treatment at a **Hospital** but is actually takenwhile confined at home under any of the following circumstances:

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

Def. 16. **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. 17. **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. 18. **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. 19. **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. 20. **Illness/Illnesses**means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

(a) Acute condition - Acute condition is a disease, **Illness** or **Injury** that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/**Illness/Injury** which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, **Illness**, or **Injury** that has one or more of the following characteristics:

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

Def. 21. **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. 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. **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. 25. **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. 26. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 27. **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. 28. **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. 29. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Medical Practitioner (Definition applicable for the treatment taken outside India)

Means a licensed medical practitioner acting within the scope of his license and who holds a degree of a recognized institution and is registered by the Authorized Medical Council of the respective country.

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

i. 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
ii. 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. 36. **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. 37. **Pre-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined number of days preceding the **Hospitalization** of the Insured Person, provided that:

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

i. Such **Medical Expenses** are for the same condition for which the insured person's **Hospitalization** was required, and

ii. The inpatient **Hospitalization** claim for such **Hospitalization** is admissible by the insurance company**.**

Def. 39. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 40. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of **Grace Period** for treating the **Renewal** continuous for the purpose of gaining credit for **Pre-Existing Diseases**, time-bound exclusions and for all waiting periods

Def. 41. **Room Rent** means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the associated **Medical Expenses**

Def. 42. **Reasonable and Customary Charges**means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services ,taking into account the nature of **Illness**/ **Injury** involved.

Def. 43. **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.

Def. 44. **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.

II. Specific Definition

Def. 1. **Adventurous/Hazardous Sports means** any sport or activity involving physical exertion and skill in which an **Insured Person** participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

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

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

Def. 4. **Aggregate Deductible:** Aggregate deductible is a cost-sharing requirement under a health insurance policy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. An Aggregate deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalization expenses incurred which are admissible under this Policy (and not excluded) during the policy year by insured person (individual Sum Insured policy) or insured family (in case of floater sum insured policy).

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

Def. 6. **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 7. **Base Sum Insured** means the sum shown in the Policy Schedule which represents **Our** maximum liability for respective Cover during the life time of the Policy.

Def. 8. **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. 9. **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. 10. **Bological 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. 11. **Catastrophic Event** means and includes Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood, Inundation and Earthquake

Def. 12. **Chemical attack** or **weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 13. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule.

Def. 14. **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. 15. **Common Carrier** means any land, sea or air conveyance operated under a licence issued by a governmental authority having jurisdiction, for the transportation of fare paying passengers and which has fixed, established routes only.

Def. 16. **Dependent Child/Children** means living dependent child or children of **Insured Person** up to age of 25 years as on date of **Injury**, including legally adopted and step- children.

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

a) **Your** legally married spouse as long as she continues to be married to You
b) **Your** children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households;
c) **Your** natural parents or parents that have legally adopted You, and **Your** parent in laws

Def. 18. **Dependent Parents** means **Your** natural parents, parents that have legally adopted you or **Your** parents in law.

Def. 19. **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. 20. **Insured Person** means **You** and the persons named in the Policy Schedule who are insured under the Policy.

Def. 21. **Immediate Family** mean an **Insured Person**'s Spouse; children; children-in-law, siblings; siblings-in-law; parents; parents-in-law; grandparents; grandchildren; legal guardian, ward, step or adopted children; step-parents; aunts, uncles; nieces, and nephews.

Def. 22. **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. 23. **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. 24. **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. 25. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence;

Def. 26. **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. 27. **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. 28. **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. 29. **HDFC ERGO Mobile App**is proprietary App of HDFC ERGO General Insurance Company. With my: thisApp you can:

- Access **Your** Policy Details
  - Manage **Your** policy, download **Your** policy schedule and access to **Your** e-card will always be at **Your** fingertips, 24 x 7.
- Policy Endorsement made easy
  - By submitting a request to us through **HDFC ERGO Mobile App**, you can make any modifications in **Your** policy, for e.g. change in spelling of the name, contact number etc.
- Effortless Claims Management
  - Now you can submit **Your** claims from the app for faster processing and track the status at **Your** fingertips. You can also intimate a claim using the app. You can also view Network hospitals in **Your** area with directions.

- Stay Active – Short Walks, Big Benefits
  - The App tracks **Your** steps, fitness session and lets you earn incentive on renewal discount on **Your** policy.

Def. 30. **Non-Medical Expenses –** Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergo.com

Def. 31. **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. 32. **Permanent Total Disablement** means that the **Insured Person** is totally disabled from undertaking all the material duties of his/her usual occupation for which the **Insured Person** is reasonably fitted by training, education or experience for a continuous period of 365 days and, at the expiration of the 365 days period, it is reasonably certain that such disability will persist throughout the Insured Person's lifetime.

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

Def. 36. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 37. **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. 38. **Policy Year**means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

Def. 39. **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. 40. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of **Your** Dependents during the Policy Year

Def. 41. **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. 42. **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. 43. **Temporary Total Disablement** means disablement which temporarily and entirely prevents an **Insured Person**from engaging in or giving attention to the *Insured Person's* usual occupation for a continuous period mentioned in the Schedule of Coverage on the Policy Schedule.

Def. 44. **Temporary Partial Disablement** means disablement which temporarily and partially prevents an **Insured Person**from engaging in or giving attention to the *Insured Person's* usual occupation.

Def. 45. **We/Our/Us/Insurer/Company** means the HDFC ERGO General Insurance Company Limited

Def. 46. **You/Your** means the Insured Person named in the Policy Schedule who is insured under the Policy

III. Definition: Major Illnesses – applicable to optional cover 4 under Section 1

i. Standard Definitions

1. Cancer of specified severity

A malignant tumor 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 leukemia, lymphoma and sarcoma.The following are excluded:

i. All tumors which are histological described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, 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 tumors of the prostate unless histological classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histological classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histological described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumorshistological classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Kidney failure requiring regular dialysis

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

3. 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:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

4. 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.

5. 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.

6. 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:
Angioplasty and/or any other intra-arterial procedures

7. Open Heart Replacement or Repair of Heart Valves

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

8. Permanent Paralysis of Limbs

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

9. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial source.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 – Benefits, Exclusions & Claims Procedure

Section 1 – Health

Preamble

We will provide Insurance coverage to the **Insured Person**(s) under this **Policy** up to **Sum Insured** including **Cumulative Bonus** as applicable and subject to waiting periods, limits, Procedure sub-limits, **Co-payment**,**Deductible**, **Aggregate Deductible** as specified on the Schedule of Coverage in the Policy Schedule.The **Policy** is based on statements, disclosures, declarations made in the Proposal form andMedical 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 1.A. Benefits

I. Hospitalization Expenses

We will pay under below listed Covers on **Medically Necessary Hospitalization** of an **Insured Person** due to **Illness** or **Injury** sustained or contracted during the **Policy Period** and subject to terms and conditions as listed below.

1. Medical Expenses

i. **Room Rent** and boarding charges
ii. **Intensive Care Unit** charges
iii. Consultation fees & Nursing charges

iv. Anesthxesia, blood, oxygen, operation theatre charges, surgical appliances charges
v. Medicines, drugs and consumables
vi. Diagnostic procedures conducted with in same hospital where Insured Person is admitted
vii. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

a. Special Conditions;

The Claims under Cover 1.Medical Expenses are subject to terms and conditions given below.

i. **Room Rent & Proportionate deduction: Insured Person** is eligible for **Room Rent** category of up to Single Standard AC Room. In case of admission to a room exceeding the aforesaid category, 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.**

ii. **Procedure Sub-limits:** The Claim under Cover 1. Medical Expenses is subject to Sub-limits for **Illnesses** as mentioned below. The maximum amount payable under the **Policy** for all coverage put together under Section 1.A - I. Hospitalization Expenses shall be subject to maximum amount as mentioned in the Table I below.

Table I

Procedure	Sub-Limits (Rs)
Cataract per eye	75,000
Surgeries forBenign - Tumors / Cysts / Nodule / Polyp	75,000
Stone in Urinary System	75,000
Hernia Related	75,000
Appendisectomy	75,000
Hysterectomy	75,000
Fissures / Piles / Fistulas	75,000
Cellulites / Abscess	75,000

iii. Mental Illness

The Coverage for Mental illness is applicable if done in **Mental Health Establishment** and is subject to the provisions contained in the Mental Health Care Act, 2017, as amended from time to time and other applicable laws and Regulations

2. Home Healthcare

Insured Person can avail **Hospitalization** at Home under Home Healthcare for **Medically Necessary Treatment** of **Illnesses** , if prescribed by treating **Medical Practitioner**. We will pay Medical Expenses incurred as admissible under A(I)(1) for treatment of such **Illness** where availed.

This Cover can be availed through **Cashless Facility** only as procedure given under Claims Procedure – Section 1.A - VI .

3. Domiciliary Hospitalization

We will pay the **Medical Expenses** incurred on **Domiciliary Hospitalization** of the **Insured Person** presecribed by treating **Medical Practitioner** provided that:

i. the condition of the **Insured Person** is such that he/she could not be removed to a **Hospital**
or
ii. the **Medical Necessary Treatment** is taken at Home on account of non-availability of room in **Hospital**

4. Pre-Hospitalization cover

We will pay for the **Pre- HospitalizationMedical Expenses** incurred during the 60 days immediately before **Hospitalization** of an **Insured Person**, provided that such **Medical Expenses** are incurred for the same **Illness**/**Injury** for which subsequent **Hospitalization** was required and Claim under Section 1.A1 , 1.A2, 1.A3or 1.A6 is admissible under the **Policy**.

5. Post-Hospitalization cover

We will pay for the **Post HospitalizationMedical Expenses** incurred upto180 days from the date Insured Person is discharged from Hospital provided that such costs are incurred in respect of the same **Illness**/**Injury** for which the earlier **Hospitalization** was required and Claim under Section 1.A.1, 1.A.2, 1.A.3 or 1.A.6 is admissibleunder the **Policy**

6. Day Care Procedures

We will pay for the **Medical Expenses** under Section 1.A.I.1 on **Hospitalization of Insured Person** in **Hospital** or **Day Care Centre** for **Day Care Treatment.**

7. Road Ambulance

For each admissible Claim under Section 1.A.I.1 andA.I.6, We will pay 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**

8. Organ Donor Expenses

We will pay **Medical Expenses** coveredunder Section 1.A.I.1 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 1.A.1 is admissible under the **Policy** for the **Insured Person**
iii. The Organ Donor's **Pre-Hospitalization** and **Post-Hospitalization** expenses are excluded under the Policy
iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy

9. Alternative Treatments

We will indemnify the **Medical Expenses** covered under Section 1.A.I.1 only on In-patient care of **Insured Person** in an **AYUSH Hospital** upto the limits specified in the policy schedule only for the below mentioned **Alternative Treatments** prescribed by **Medical Practitioner**

- Ayurvedic
- Unani
- Siddha
- Homeopathy
- Yoga & Naturopathy

II. Value added Services under Section 1– Health

i. Health Coach:

Insured Person will have access to Health Coaching services in areas given below :

- Disease management
- Activity and fitness
- Nutrition
- Weight management
- Psychological counselling
- Depression counselling

These services will be available through **Our HDFC ERGO Mobile App** as a chat service or as a call back facility.

ii. Wellness services

- **Discounts:** on OPD, Pharmaceuticals, pharmacy, diagnostic centres
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** stress management, Pregnancy Care, Work life balance management.

III. my:health Active

1. Preventive Health Check-Up

Insured Person will be entitled for below list of tests after completion of each **Policy Year/Renewal** at our **Network Provider** ;

- Chest X Ray
- 2D echo/ Stress test
- PSA for Males
- PAP smear for Females
- Medical Examination Report
- Complete Blood Count Urine R
- Fasting Blood Sugar
- Serum Creatinine
- Lipid Profile
- Electro Cardio Gram

Other terms and Conditions applicable to this Benefit

- This benefit will not be carried forward if not utilized within 60 days of end of Policy Year or Renewal.
- The test reports received under this benefit will not be utilized for re-underwriting the coverage of I**nsured Person**

Procedure for availing this benefit

i. **You** will be intimated to undergo the health check-up at our **Network Provider**, through **Our HDFC ERGO Mobile App.**
ii. Test reports from our **Network Provider** will be made available to **You** on **Our HDFC ERGO Mobile App**
iii. **You** have the option to avail this benefit at our **Network Provider** through Phone/Email or other modes of communication as available from time to time.

2. Fitness discount @ Renewal

Insured Person can avail discount on **Renewal** Premium by accumulating Healthy Weeks as per table given below. One Healthy Week can be accumulated by;

- Recording minimum 50,000 steps in a week subject to maximum 15,000 steps per day, tracked through **Your** wearable device linked to **Our HDFC ERGO Mobile App**and **Your Policy** number
  OR
- burning total of 900 calories up to maximum of 300 calories in one exercise session per day, tracked **Your** wearable device linked to **Our HDFC ERGO Mobile App**and **Your Policy** number
- Fitness discount @ Renewal is applicable for Adult Insured Persons only. Any Person covered as Child Dependent, irrespective of the Age is excluded.

Healthy Weeks Discounts

No. of Healthy Weeks Accumulated during the Policy Year	Discount on Renewal Premium
1-4	0.50%
5-8	1.00%
9-12	2.00%
13-16	3.00%
17-26	6.00%
27-36	7.50%
Above 36	10.00%

Maximum discount offered each Policy Year on account of Healthy Weeks will be 10% subject to Insured Person meeting the criteria as mentioned in above. **Steps to accumulate Healthy Weeks**

1. The**HDFC ERGO Mobile App**must be downloaded on the mobile.
2. **You** can start accumulating Healthy Weeks by tracking physical activity through the wearable device linkedto **Our**HDFC ERGO Mobile Appand**YourPolicy** number

We encourage and recognize all types of exercise/fitness activities by making use of wearable devices to track and record the activities **Insured Person** engages in.

Application of Fitness discount @ Renewal

- **Annual Policy**: Discount amount accrued based on Number of accumulated Healthy Weeks during the expiring **Policy Year** will be applied on the **Renewal** Premium for expiring **Policy Sum Insured** and for **Insured Person(s)** covered under expiring Policy
- **Multi Year Policy**:
    - Fitness discount earned on yearly basis will be accumulated till Policy End date.
    - On **Renewal** of the Policy, total discount amount accrued each **Policy Year** will be applied on **Renewal** Premium of subsequent year and for **Insured Person(s)** covered under expiring Policy.
    - The maximum discount offered each Policy Year will be 10% subject to maximum 20% for two Year Policy and 30% for three Years Policy.
- For Policies covering more than one **Insured Person**, Healthy Weeks for each **Insured Person** will be tracked and accrued. Such discount will be applicable on individual **Renewal** Premium for both Individual and Floater Sum Insured basis Policies.
- Premium will be discounted to the extent applicable to coverage corresponding to expiring **Policy**.
- In case of Increase in Sum Insured at **Renewal**, discount amount will be applied on the premium corresponding to the **Sum Insured of the expiring Policy**.
- Fitness discount @ Renewal will be applied only on **Renewal** of **Policy** with **Us** and only if accrued**.**

3. Health Incentives

This Program encourages **Insured Persons** to maintain good health and avail incentives as listed below.

Under this Program, **Insured Person** having **Pre-Existing Diseases** or Obesity (BMI above 30) as listed under table A below, will be eligible for reduction in Medical Underwriting Loading applied on first inception of the Policy with Us provided that;

i. **Insured Person** shall undergo medical tests and/or BMI check-up as listed below minimum 3 months prior to expiry of Policy Year (For Multiyear Policies) or before Renewal (For Annual Policies).
ii. Medical test shall be done at **Your** own cost through our **Network Provider** on **Our HDFC ERGO Mobile App**.
iii. If the test parameters are within normal limits, **We** will apply 50% discount on the Medical Underwriting loading applied for corresponding **Pre-Existing Disease** or Obesity as applicable on **Renewal** of the Policy with **Us.**
iv. If the test parameters at subsequent **Renewal** are not within normal limits or Medical test reports are not submitted in accordance with i and ii above, the discount amount applied on Medical Underwriting loading will be zero

Table A

Pre-existing Diseases	Test
Diabetes	HbA1c
Hypertension	Blood Pressure reading
Hyperlipidemia	Total Cholesterol
Cardiovascular Diseases	ECG
Hypothyroidism	Thyroid function tests
Obesity	BMI

Application of Health Incentive

- **Annual Policy**: Discount amount accrued during the expiring Policy year will be applied on the **Renewal** Premium corresponding to expiring Policy Sum Insured and for **Insured Person** covered under the expiring Policy
- **Multi Year Policy**:
    - Discount amount earned on yearly basis will be accumulated till Policy End date.
    - On Renewal of the Policy, total discount amount accrued each year will be applied on **Renewal** Premium of subsequent year and for **Insured Person** covered under the expiring Policy
- For Policies covering more than one Insured Person, tests shall be done for each Insured Person basis which such reduction in loading where ever applicable will be applied on individual **Renewal** Premium for both Individual and Floater Sum Insured basis Policies.
- Medical Underwriting loading will be discounted only on **Renewal** of **Policy** with **Us** and only for **Insured Person** covered under such expiring Policy
- Discount on Medical Underwriting loading under this cover is applicable only on next **Renewal** and cannot be utilized if Policy not renewed with us.

4. Cumulitive Bonus

On Renewal of this Policy with the Company without a break, a sum equal to 50% of the Base Sum Insured of the expiring Policy shall be provided as Cumulative Bonus irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions:

i. **Cumulative Bonus** can be accumulated upto 100% of Basic **Sum Insured**.
ii. **Cumulative Bonus** applied will be applicable only to **Insured Person(s)** covered under the expiring Policy and who continue to remain insured on **Renewal**.

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.

This benefit is not applicable if Optional Cover 2, **Aggregate Deductible** is opted under Section 1 of the **Policy**

IV. Optional Covers under Section 1

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 expenses under below listed Covers subject towaiting periods, limits, Procedure sub-limits, **Co-paymentDeductible** and **Aggregate Deductible** as specified on the Schedule of Coverage in the Policy Schedule.

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.

1. Non-Medical Expenses cover

We will pay for **Non-Medical Expenses** up to the limit mentioned in Schedule of Coverage in the Policy Schedule for claims admissible under Section 1.I

In view of this Cover, Exclusion (xxx) of V. What is not covered shall stand covered up to the extent mentioned above.

2. Aggregate deductible

On availing this option, the Insured Person shall bear an amount equal to the **Aggregate Deductible** specified in the **Schedule of Coverage** on **Policy Schedule** for all admissible claim amounts assessed by **Us** in respect of all claims made by **Insured Person** in a **Policy Year**. The liability of the Company to pay the admissible Claim under that Policy Year will commence only once Aggregate Deductible has been exhausted.

Special Conditions applicable to this Cover

i. This Cover can be opted only at first inception of the **Policy** and is not available at **Renewal**

ii. Once the **Aggregate Deductible** option is availed by the **Insured Person**, it cannot be opted out of at subsequent **Renewal**.

3. Emergency Medical Expenses

On availing this option, We will pay **Medical Expenses** under Section 1 on **Medically Necessary Hospitalization** of an **Insured Person** outside India due to **life threatning situation**, up to limits specified in the Schedule of Coverage on Policy Schedule, provided that :

i. The treatment is **Medically Necessary** and has been certified as **life threatening Situation** by a **Medical Practitioner**, where such treatment cannot be postponed until the **Insured Person** has returned to India.
ii. The Medical Expenses payable shall be limited to coverage under 1.I - 1, 5, 6 and 9 only.

and subject to waiting period and exclusions mentioned under V. What is not covered.

4. Overseas Treatment

On availing this Option, We will pay the **Medical Expenses** incurred outside India under Sections and covers mentioned below for **Major illnesses**, whose diagnosis first commence/occurs after the applicable waiting period from commencement of the first Policy with Us.

Coverage under Section:

I. Hospitalization Expenses		**III. Optional Covers**	
1	Medical Expenses	1	Non-Medical Expenses cover
4	Pre-Hospitalization cover	8	Medical Evacuation
5	Post-Hospitalization cover		
6	Day Care Procedures		
7	Road Ambulance		
8	Organ Donor Expenses		
9	Alternative Treatments		

5. Waiver of Disease Capping:

On availing this option, Procedure Sub-Limits listed under Section 1.A.I.1.a – Medical Expenses, shall stand deleted under the Policy.

6. Waiver of Room Rent Capping

On availing this option, the limits specified with respect to Room Rent/Boarding charges under Section 1.A.I.1.a.i – Medical Expenses shall stand deleted under the Policy.

7. Waiting period Modification Option

On availing this option, **Waiting Periods** listed under Section 1.A.V.I.i shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule.

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

8. Medical Evacuation

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 up to the actual expenses subject to a maximum of **Sum Insured** as specified on the Schedule of Coverage in the Policy Schedule.

Specific Exclusion:

We will not pay for return transportation to the Insured Person's home by air ambulance

9. Sum Insured Rebound

We will add to the Sum Insured, an amount equivalent to the Claim amount paid under Basic Sum Insured, subject to maximum of Basic Sum Insured, onsubsequent **Hospitalization** of the**Insured Person** during Policy Yearssubject to;

i. Total Sum Insured added under this cover will not exceed the Basic Sum Insured in a Policy Year
ii. Total of Basic Sum Inured under Hospitalization Cover, Cumulative Bonus earnedand Sum Insured Rebound will be available to all Insured Persons for all claims under Section 1 during the current Policy Year and subject to the condition that a single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative Bonus earned .
iii. In case of treatment for Chemotherapy and Dialysis, Sum Insured Rebound will be applicable only once in lifetime of **Policy**
iv. This cover will be applicable annually for policies with term more than one year.
v. Any unutilized amount of Sum Insured Rebound cannot be carried over to next **Policy Year** or **Renewal Policy**
vi. Sum Insured Rebound can be utilized for Claims under Section 1.I only.
vii. This Cover is not applicable if Optional Cover 2,**Aggregate Deductible** is opted under Section 1 of the Policy

Illustration 1

Time	Claim no.	Sum Insured available	Cumulative Bonus available	Admissible Claim amount	SI Rebound Available	Total SI Rebound till date	Payable amount
3 months	1	3,00,000	30,000	2,50,000	0	0	2,50,000
5 months		50,000	30,000	1,40,000	0	0	80,000
9 months	2	0	0	2,50,000	3,00,000	3,00,000	2,50,000
11 months	3	0	0	70,000	50,000	3,00,000	50,000

Illustration 2

Time	Claim no.	Sum Insured available	Cumulative Bonus Available	Admissible Claim amount	SI Rebound Available	Total SI Rebound till date	Payable amount
3 months	1	3,00,000	30,000	2,50,000	0	0	2,50,000
6 months	2	50,000	30,000	1,40,000	2,50,000	2,50,000	1,40,000
9 months	3	0	0	2,50,000	=250,000-60,000+50,000 =240,000	3,00,000	2,40,000
11 months	4	0	0	70,000	0	3,00,000	0

10. Waiver of Co-Payment

On availing this option, applicable**Co-Payment**stands waived under the Policy.

11. Cumulative Bonus – Booster

On availing this cover, **Cumulative Bonus** percentage mentioned under Section 1.A.III.4 – Cumulative Bonus will stand modified as mentioned in Schedule of Coverage on the Policy Schedule subject to;

i. Once the **Cumulative Bonus**- **Booster** benefit is availed by the Insured Person, it cannot be opted out at subsequent **Renewal**.
ii. All other terms and Conditions of Section 1.A.III.4. Cumulative Bonus shall remain unaltered.

Section 1.B. Exclusions & Waiting Period

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

I. Standard Waiting Periods

Claims under the Policy are covered subject to Co-payment &waiting Period as specified below:

i) **Pre-existing Diseases – 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 36 months of continuous coverage after the date of inception of the first 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 36 months 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 waiting period**- Code – Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident**.
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

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

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

ii) **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.

II. Specific- Co-payment

a) **Insured Person** shall bear specified percentage of admissible Claim amount under each and every Claim, where Co-payment is applicable and as specified in the Schedule of Coverage in the Policy Schedule.

b) The **Co-payment** in respect of **Insured Person** with **Pre-existing diseases** will be applicable only during waiting period applicable to **Pre-existing diseases.**

III. Stanadard Permanent Exclusions

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

i. **Investigation & Evaluation:**Code Excl04

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

ii. **Rest Cure, rehabilitation and respite care**–Code – Excl05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. **Obesity/Weight control:**Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the doctor
   b. The surgery/procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI)
      i. Greater than or equal to 40 or,
      ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         1. Obesity related cardiomyopathy
         2. coronary heart disease
         3. severe sleep apnoea
         4. uncontrolled type2 diabetes

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

v. **Cosmetic or plastic surgery:**Code – Excl08:Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of **Medically Necessary Treatment** to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending **Medical Practitioner.**

vi. **Hazardous or Adventure Sports**Code – Excl09– Expenses related to any treatment necessitated due to participation as a professional in **Hazardous** or **Adventure sports**, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

vii. **Breach of Law:**Code – Excl10 - Expenses for treatment directly arising from or consequent upon any **Insured Person** committing or attempting to commit a breach of law with criminal intent.

viii. **Excluded Providers-** Code – Excl11 Expenses incurred towards treatment in any hospital or by any **Medical Practitioner** or any other provider specifically excluded by the **Insurer** and disclosed in its website/notified to the policyholders are not admissible. However, in case of **life threatening situations** or following an **Accident,** expenses up to the stage of stabilization are payable but not the complete claim.

ix. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.Code – Excl12

x. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.Code – Excl13

xi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a **Medical Practitioner** as part of **Hospitalization** claim or day care procedure.Code – Excl14

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

xiii. **Unproven Treatments–** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.Code – Excl16

xiv. **Sterility and Infertility –**Code – Excl17 -Expenses related to sterility and infertility. This includes:
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization

xv. **Maternity:**Code – Excl18
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

IV. 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 opted and as mentioned on the Schedule of Coverage in the Policy Schedule.
iii. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
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.
ix. Investigative treatments for analysis and adjustments of spinal subluxation,diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
x. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).
xi. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
xii. Preventive care,; and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
xiii. Vaccination including inoculation and immunisations (Except post Animal bite treatment),
xiv. **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.
xv. Treatment taken on Outpatient basis
xvi. The provision or fitting of hearing aids, spectacles or contact lenses.
xvii. 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.
xviii. 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.
xix. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com
xx. Any Claim arising due to Non-disclosure of Pre-existing **Illness** or Material fact as sought to be declared on the Proposal form.

Section 1.C. Claims Procedure – Section 1 – Health

1. Notification of a Claim

Procedure	**Cashless Hospitalization**		**Cashless claims for Hospitalizations outside India**	**Reimbursement Claims**	**Home Healthcare 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				
		At least 72 hours prior to	Within 24 hours of the Emergency Hospitalization	Within 48 hours of admission or	

Claim Intimation Timelines	Within 24 hours of the Hospitalization	theplanned Hospitalization	At least 72 hours prior to the planned Hospitalization	before discharge from the **Hospital,** whichever is earlier	Immediately on diagnosis of **Illness**
Particulars to be provided to Us for Claim notification	i. The health card issued by **Us** ii. KYC documents iii. The Policy Number iv. Name of the **Policyholder** v. Name and address of **Insured Person** in respect of whom the request is being made vi. Nature of the **Illness/Injury** and the treatment/**Surgery** required vii. Name and address of the attending Medical Practitioner viii. Hospital where treatment/**Surgery** is proposed to be taken or /**Hospital** where the **Insured person** is admitted ix. Proposed /Actual Date of admission				**Following particulars in addition to those listed under Hospitalization Claim:** i. Treatment details ii. Preferred date and time for initial assessment
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the **Insured person**(s) named in the Policy schedule availing treatment 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 vii. Any other relevant information as required			Not Applicable	**Following particulars in addition to those listed under Hospitalization Claim:** Probable date of start of treatment
Process for obtaining Pre-Authorization	i. If the particulars are not provided in full or are insufficient for **Us** to consider the request, We will request additional information or documentation ii. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, **We** may; • Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or • Reject the request for pre-authorization specifying reasons for the rejection.		i. **We** shall send Release of Information form to the Insured Person for signature and consent. ii. After receiving the signed Release Of Information form, **We** will retrieve hospitalization documents along with invoices iii. If these details are not provided in full or are insufficient for **Us** to consider the request, We will request additional information or documentation iv. On receipt of the complete		On receipt of duly filled pre authorization form with other sufficient details to assess the request, **We** will inform our Home Healthcare service provider who will follow the following process: i. Meet the treating medical practitioner and verify the requirement along with the prescription/discharge summary (if applicable) and the condition of the patient ii. Verify the past medical history of the patient iii. Complete physical examination of the patient iv. Check if the patient requires any equipment, devices etc. v. Share the care plan and treatment cost estimation with **Us**. v. On receipt of the complete documents **We** may; • issue the authorization letter specifying the

		documents **We** may • issue the guarantee of payment specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable or or • reject the request for pre-authorization specifying reasons for the rejection		sanctioned amount, any specific limitation on the claim and non-payable items, if applicable or • reject the request for pre-authorization under Home Healthcare specifying reasons for the rejection. On rejection of Pre-Authorization under Home Healthcare, Claim procedure under Cashless treatment or Reimbursement may be followed.
List of Claim documents	Not Applicable		As enlisted below	Not Applicable
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. 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 GIC or certificate from hospital authorities providing facilities available including number of beds.
v. Original Discharge Card / Day Care Summary / Transfer Summary
vi. Original final hospital bill with all original deposit and final payment receipt and refund receipt(s), if advance amount refunded
vii. Original 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 original diagnostic reports (including imaging and laboratory) along with prescription by **Medical Practitioner** and invoice / bill with receipt from diagnostic centre
x. All original 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. Original 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 Proposer carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Proposer. ***
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 proposer, the same document reuqirement would be for nominee/legal heir of proposer(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility

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

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
iii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the **Policyholder** from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.
iv. However, where the circumstances of a claim warrant an investigation in the opinion of the **Company**, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the **Company** shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
v. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the **Policyholder** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.
vi. If **We**, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.
vii. If requested by **Us,** at **Our** cost, the **Insured Person** must submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and **We/Our** representatives must be permitted to inspect the medical and Hospitalization records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.
viii. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess **Our** liability and quantum in respect of the claim

Section 2 – Personal Accident

Preamble

We will provide Insurance coverage to the **Insured Person**(s) under this **Policy** up to maximum of **BaseSum Insured** as applicable and subject to limits, sub-limits, **Co-payment, Time Deductible** and **Deductible** as specified on the Schedule of Coverage in the Policy Schedule.

The Coverage under this **Policy** is subject to Covers opted, statements and disclosures made in the Proposal form, declaration and/or medical reports, and the terms and conditions of this **Policy**.

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 2.A. Benefits

I – Coverage

1 – Accidental Death

I. Accidental Death

We will pay the **Sum Insured**, as specified in the Schedule of Coverage on **Policy Schedule**, if **Insured Person** sustains **Injury** due to **Accident** during the **Policy Period**, which shall within twelve months of its occurrence be the sole and direct cause of Death of **Insured Person.**

i. Disappearance

We will pay the **Sum Insured** in the event if Insured Person's body cannot be located within 365 Days;

a. after the forced landing, stranding, sinking or wrecking of a conveyance in which **Insured Person** was known to be a passenger during **Policy Period** or;
b. after and as a result of any **Catastrophic Event** during **Policy Period**

it shall be deemed, subject to all other terms and provisions of the Policy, that Insured Person shall have suffered Death due to **Accident** under the **Policy**.

If at any time, after the payment of the **Accidental** death benefit, it is discovered that the **Insured Person** is still alive, claims settled in respect of Disapperance benefit shall be reimbursed in full to the **Company**.

ii. Comatose

If **Insured Person** sustains **Injury** during **Policy Period** which directly and independently of all other causes results in the **Insured Person**being in **Hospital**in a**Comatose State** within one month of the date of **Injury** for continuous period of more than three months, **We** will pay**Sum Insured**as mentioned in the Schedule of Coverage on Policy Schedule.

Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims. The Company's liability during the lifetime of the **Policy** will not exceed the Base **Sum Insured** in respect of the Cover

II. Specific Conditions applicable to Cover 1 – Accidental Death

The Coverage under this Section terminates on admissibility of Claim equal to the **Sum Insured**

III. Optional Cover applicable to Cover 1 – Accidental Death

i. Burns

If **Insured Person** sustains **Injury** during **Policy Period**, which solely and directly results into burns, **We** will pay in accordance with benefit table below subject to maximum of **Sum Insured**as mentioned in the **Schedule of Coverage** on **Policy Schedule**;

Description		% ofBase SumInsured payable
a. Head		
i.	Third degree burns of 8% or more of the total head surface area	100%
ii.	Second degree burns of 8% or more of the total head surface	50%
iii.	Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
iv.	Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
v.	Third degree burns of 2% or more, but less than 5% of thetotal head surface area	60%
vi.	Second degree burns of 2% or more, but less than 5% of the total head surface area	0%
b. Rest of the Body		
i.	Third degree burns of 20% or more of the total body surface area	100%
ii.	Second degree burns of 20% or more of the total body surface area	50%
iii.	Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
iv.	Second degree burns of 15% or more, but less than 20% of the total body surface area	40%

v.	Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
vi.	Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
vii.	Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
viii.	Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

Specific conditions applicable to Burns

i. If the **Injury** results in more than one of the Descriptions above, then the **Company** shall be liable for the largest **SumInsured** (as per defined Description) only.
ii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.
iii. This Cover terminates on admissibility of Claim(s) equal to the **Sum Insured.** The Company's liability during the lifetime of the **Policy** will not exceed the **BaseSum Insured** in respect of the Cover..

2 – Permanent Disablement

I. Permanent Disablement

If **Insured Person** sustains **Injury** during **Policy Period**, which shall within twelve (12) months of its occurrence be the sole and direct cause of Permanent Disablement, We will pay in accordance to the Benefit table below upto maximum of **Sum Insured**as mentioned in the **Schedule of Coverage** on **Policy Schedule** provided such disablement is certified by the **Medical Practitioner**

i. Benefit Table A

S.No	The Disablement	*% of Base Sum Insured Payable*
1	***Permanent Total Disablement***	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two ***Limbs*** *(*physical severance of Limbs)	100%
4	Permanent Total ***Loss of Sight*** in both eyes	100%
5	Permanent Total ***Loss of Sight*** of one eye and one ***Limb*** *(*physical severance of Limbs)	100%
6	Permanent Total ***Loss of Speech***	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total ***Loss of Mastication***	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out ***Daily Activities*** essential to life without full time assistance	100%
10	Permanent Total ***Loss of Hearing*** in both ears	75%
11	Permanent Total Loss of one ***Limb*** *(*physical severance of Limbs)	50%
12	Permanent Total ***Loss of Sight*** of one eye	50%

ii. Benefit Table B

S.No	The Disablement	*% of Base Sum Insured Payable*
1	***Permanent Total Disablement***	100%
2	Permanent and incurable insanity	100%

3	Permanent Total Loss of two ***Limbs*** *(*physical severance or the total and permanent loss of use of such ***Limb****)*	100%
4	Permanent Total ***Loss of Sight*** in both eyes	100%
5	Permanent Total ***Loss of Sight*** of one eye and one ***Limb*** *(*physical severance or the total and permanent loss of use of such ***Limb****)*	100%
6	Permanent Total ***Loss of Speech***	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total ***Loss of Mastication***	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out ***Daily Activities*** essential to life without full time assistance	100%
10	Permanent Total ***Loss of Hearing*** in both ears	75%
11	Permanent Total Loss of one ***Limb*** *(*physical severance or the total and permanent loss of use of such ***Limb****)*	50%
12	Permanent Total ***Loss of Sight*** of one eye	50%

iii. Benefit Table C

S.No	The Disablement	*% of Base Sum Insured Payable*
1	***Permanent Total Disablement***	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two ***Limbs*** *(*physical severance or the total and permanent loss of use)	100%
4	Permanent Total ***Loss of Sight*** in both eyes	100%
5	Permanent Total ***Loss of Sight*** of one eye and one ***Limb*** *(*physical severance or the total and permanent loss of use)	100%
6	Permanent Total ***Loss of Speech***	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total ***Loss of Mastication***	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out ***Daily Activities*** essential to life without full time assistance	100%
10	Permanent Total ***Loss of Hearing*** in both ears	75%
11	Permanent Total Loss of one ***Limb*** *(*physical severance or the total and permanent loss of use)	50%
12	Permanent Total ***Loss of Sight*** of one eye	50%
13	**Permanent Total *Loss of Hearing*** in one ear	*15%*
14	***Permanent Total Loss of the lens in one eye***	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	

a)	All – one foot	15%
b)	Big – both joints	*5%*
c)	*Big – one joint*	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%

iv. Benefit Table D

S.No	The Disablement	*% of Base Sum Insured Payable*
1	***Permanent Total Disablement***	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two ***Limbs*** *(*physical severance or the total and permanent loss of use)	100%
4	Permanent Total ***Loss of Sight*** in both eyes	100%
5	Permanent Total ***Loss of Sight*** of one eye and one ***Limb***	100%
6	Permanent Total ***Loss of Speech***	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total ***Loss of Mastication***	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out ***Daily Activities*** essential to life without full time assistance	100%
10	Permanent Total ***Loss of Hearing*** in both ears	75%
11	Permanent Total Loss of one ***Limb*** *(*physical severance or the total and permanent loss of use)	50%
12	Permanent Total ***Loss of Sight*** of one eye	50%
13	**Permanent Total *Loss of Hearing*** in one ear	15%
14	***Permanent Total Loss of the lens in one eye***	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	
a)	All – one foot	15%
b)	Big – both joints	5%
c)	*Big – one joint*	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%

23	**Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of**	75%

II. Terms and Conditions applicable to Cover 2 – Permanent Disabelemt

i. Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to fifty percent (50%) of the **BaseSum Insured** subject to maximum of **Sum Insured**payable for the loss of the said members.
ii. Benefit under item 23 of Table D shall be determined by the independent**Medical Practitioner**who will certify the perecentage of **BaseSum Insured** payable taking into consideration the nature of the ***Injury***and disability in conjunction with the stated percentages **BaseSum Insured**for more specific injuries shown in the Table of Benefits.
iii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.
iv. The Coverage under this Section terminates on admissibility of Claim(s)equal to the **Sum Insured**.The Company's liability during the lifetime of the Policy will not exceed the **Base Sum Insured** in respect of the Cover.
v. The total amount payable in respect of more than one disablement due to the same **Injury** is arrived at by adding together the various percentages of **BaseSum Insured** shown in the Table of Benefits subject to maximum of **Sum Insured**.

3 – Temporary Total Disablement

I. Temporary Total Disablement – Accident Only

If **Insured Person** sustains **Injury** during **Policy Period**, which solely and directly results in **Temporary Total Disablement**,**We** will pay the weekly benefit upto maximum of **Sum Insured** as specified in the **Schedule of Coverage** on the **Policy Schedule**foreach continuousperiod of **Temporary Total Disablement**.

II. Temporary Total Disablement – Accident and Illness

If during Policy Period, **Insured Person**;

a) Sustain **injury**
b) Contracts**Illness**

Which solely and directly results in **Temporary Total Disalbement**, **We** will pay the weekly benefit up to maximum of**Sum Insured**as specified in the **Schedule of Coverage** on the **Policy Schedule**for each continuousperiod of **Temporary Total Disablement**.

This coverage is subject to specific exclusions applicable to Temporary Total Disablement due to illness as listed under IV –What is not covered

III. Specific Conditions applicable to Temporary Total Disablement (I) and (II)

i. If **Injury** sustained or **Illness** (as applicable)sufferedis in relation to the spine and its muscular girdle, ligamentous system, cartilage, nervous system and blood supply to the spine which is not detectable by means of radiological scanning, imaging, or neurological fallout testing, then the Company shall only be liable in respect of this Section for a maximum period of five (5) weeks and only once in lifetime of the Policy.

ii. In the event of a dispute arising as to when **Temporary Total Disablement** ceased, the date shall be finally determined by an independentMedical Practitioner who certifies:
   a. the date upon which the ***Insured Person*** recovered; or
   b. the date upon which the ***Insured Person*** recovered as far as he/she ever will; or
   c. the date from which the **Insured Person** is declared to have suffered Permanent Total Disablement

iii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.
iv. The Coverage under this Cover terminates on admissibility of Claim(s) equal to **Sum Insured**. The Company's liability during the lifetime of the Policy will not exceed the **Base Sum Insured** in respect of the Cover.

4 – Broken Bones

I. Broken Bones

If **Insured Person** sustains**Injury** during **Policy Period**, which solely and directly results into Fracture, certified by **Medical Practitioner**, We will pay in accordance to the Benefit table below upto maximum **Sum Insured**as mentioned in the **Schedule of Coverage** on **Policy Schedule**;

	Fracture	% of **Base Sum Insured** payable
1)	Fractures of the Skull: a) Compound fracture with damage to the brain tissue b) Compound fracture without damage to the brain tissue c) All other fractures	 100 75 50
2)	Fractures of hip or pelvis (excluding thigh or coccyx): a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 100 50 30 20
3)	Fracture of thigh or heel: a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 50 40 30 20
4)	Fracture of Lower Leg, Clavicle, Ankle, Elbow, Upper or Lower Arm (including wrist, but excluding Colles-type fracture): a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 40 30 20 12
5)	Fractures of Lower Jaw: a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 30 20 16 8
6)	Fractures of Shoulder Blade, Kneecap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes and heel): a) All compound fractures b) All other fractures	 20 10
7)	Colles type fracture to the Lower Arm: a) Compound b) Other	 20 10
8)	Fractures of Spinal Column (Vertebrae but excluding coccyx): a) All compression fractures b) All spinous, transverse process or pedicle fractures c) All other vertebral fractures	 20 20 10
9)	Fractures of Rib or Ribs, Cheekbone, Coccyx, Upper Jaw, Nose, Toe and toes, finger or fingers: a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 16 12 8 4

II. Specific Conditions applicable to Broken Bones

The Claims under this Section are payable subject to:

i. Extent and nature of fracture as certified by **Medical Practitioner**.
ii. The total amount payable under this Cover, in respect of more than one fracture due to the same **Injury**, will be calculated by adding the various benefits together, but shall not exceed the **Sum Insured**under this Cover.
iii. This Coverterminates on admissibility of Claim(s) equal to the **Sum Insured**.The Company's liability during the lifetime of the Policy will not exceed the **Base Sum Insured** in respect of the Cover.

5 – Emergency Medical Expenses

I. Emergency Medical Expenses

We will pay **Medical Expenses** listed below for an **Emergency Care** of an **Insured Person** due to an **Injury** sustained during the Policy Period up to **Sum Insured** as mentioned in the **Schedule of Coverage** on the **Policy Schedule**, subject to **Co-Payment**, **Deductible and Sub-limit** as applicable and within India only.

Medical Expenses

1. **Room Rent** and boarding charges in the event of **Hospitalization** of **Insured Person**
2. **Intensive Care Unit** charges in the event of **Hospitalization** of **Insured Person**
3. **Post Hospitalization expenses** up to 30 days
4. Consultation fees& Nursing charges
5. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
6. Medicines, drugs and consumables
7. Diagnostic procedures
8. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.
9. Medical Expenseslisted above for **Domiciliary Hospitalization** in India only
10. Road Ambulance: if following an **Injury,** Insurance Person is required to be Hospitalized, we will indemnify the cost of Road Ambulance;
    - to the nearest **Hospital**
    - from one **Hospital** to another **Hospital**
    - or from **Hospital** to Home (within same City)

11. **Room Rent** & Proportionate deduction: In the event of **Hospitalization**, **Insured Person** is eligible for **Room Rent** category of up to Single Standard AC Room. In case of admission to a room exceeding the aforesaid category, the reimbursement/payment of Room Rent charges including all **Associated Medical Expenses**(excluding Medicines and drugs)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

Note pertaining specifically to AYUSH Treatments only:

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

II. Optional Covers under Emergency Medical Expenses

i. Emergency Medical Expenses - Global

On availing this option, **We** will pay **Medical Expenses** under I. Emergency Medical Expenses, incurred anywhere in world.

ii. Co-payment

On availing this option, **Co-Payment** will be applicable as mentioned in the **Schedule of Coverage** on the **Policy Schedule** on all Claims under Cover 6 – Emergency Medical Expenses

6– Hospital Cash – Accident only

I. Hospital Cash – Accident Only

If Insured Person sustains Injury, which with in month of its occurance, results in **Medically Necessary**;

i. **Hospitalization**
ii. Domiciliary **Hospitalization**
iii. **In-patient care Hospitalization** for Alternative Treatments

of an **Insured Person**within India**, We** will pay per day**Sum Insured**subject to maximum maximum number of benefit daysas specified on the **Schedule of Coverage** in the **Policy Schedule** for each continuous and completed period of 24 hours of such Hospitalization.

II. SpecificConditions applicable to Cover Hospital Cash – Accident only

For the purpose of application of **Time Deductible**,successive **Hospital**stays with less than sixty daysbetween each one for a same cause, shall be deemed as one **Hospitalization** event.

III. Optional Covers applicable to Cover Hospital Cash – Accident only

i. Companion Benefit

In the event of admissible Claim under this Cover, **We** will pay additional **Sum Insured**as specified on the **Schedule of Coverage** in the **Policy Schedule** towards expenses of an accompanying person during **Hospitalization** of the **Insured Person**.

ii. Hospital Cash –ICU

We will pay **Sum Insured** as specified on the **Schedule of Coverage** in the **Policy Schedule** for each continuous and completed period of 24 hours of **Hospitalization** of **Insured Person** in the **Intensive Care Unit**.

iii. Time Deductible Modification Option

On availing this option, **Time Deductible** as mentioned on the Schedule of Coverage in the **Policy Schedule** will be applied on each and every admissible Claim under the **Policy**.

iv. Hospital Cash – Global

On availing this option, we will pay **Sum Insured**as specified on the **Schedule of Coverage** in the **Policy Schedule** on **Medically Necessary Hospitalization** of an **Insured Person** outside India due to **Injury** sustained during **Policy Period**.

7- Chauffeur Benefit

I. Chauffeur Benefit

If Insured Person sustains **Injury**during the Policy Period which results in **Temporary Total Disalblement** or **Temporary Partial Disablement**, We will indemnify the **Insured Person** towards daily cost of hire of a transportation or driver to maintain the mobility of **Insured Person**. The Coverage is applicable forperiod of disablement subject to maximum number of days and **Sum Insured** specified in the Schedule of Coverage on the Policy Schedule.

II. Specific Conditions applicable to Chauffeur Benefit

i. This cover is applicable only on certification of Travel by **Medical Practitioner**.
ii. In the event of Claim admissible under this Cover, no claim shall be payable under Cover 3 – Temporary Total Disablement

iii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.
iv. The Coverage under this Cover terminates on admissibility of Claim(s) equal to the **Sum Insured**.The Company's liability during the lifetime of the **Policy** will not exceed the **BaseSum Insured** in respect of the Cover.

II. Value added Services under Section 2– Personal Accident

i. Health Coach:

Insured Person will have access to Health Coaching services in areas given below :

- Disease management
- Activity and fitness
- Nutrition
- Weight management
- Psychological counselling
- Depression counselling

These services will be available through **Our HDFC ERGO Mobile App**as a chat service or as a call back facility.

ii. Wellness services

- **Discounts:** on OPD, Pharmaceuticals, pharmacy and diagnostic centres
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** stress management, Pregnancy Care, Work life balance management.

III. Optional Covers under Section 2 – Personal Accident

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 expenses under below listed Covers subject to 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.

i. Preventive Health Check-up

Insured Person will be entitled for below list of tests after completion of each **Policy Year/Renewal** at our **Network Provider** ;

- Chest X Ray
- 2D echo/ Stress test
- PSA for Males
- PAP smear for Females
- Medical Examination Report
- Complete Blood Count Urine R
- Fasting Blood Sugar
- Serum Creatinine
- Lipid Profile
- Electro Cardio Gram

Other terms and Conditions applicable to this Benefit

- This benefit will not be carried forward if not utilized within 60 days of Policy anniversary date.
- The test reports received under this benefit will not be utilized for re-underwriting the coverage of I**nsured Person**

Procedure for availing this benefit

i. **You** will be intimated to undergo the health check-up at our **Network Provider**, through **Our HDFC ERGO Mobile App.**

ii. Test reports from our **Network Provider** will be made available to **You** on **Our HDFC ERGO Mobile App**
iii. **You** have the option to avail this benefit at our **Network Provider** through Phone/Email or other modes of communication as available from time to time.

ii. Last Rites

On availing this option, **We** will pay the **Sum Insured** towards Last Rites of **Insured Person** in the event of admissible Claim under Cover 1 – Accidental Death.

The Coverage for this Optional cover terminates on admissibility of Claim equal to the **Sum Insured**

iii. Dependent Children Education Benefit

We will pay the **Sum Insured** towards education of **Dependent Children**, in the event of Claim admissible under Cover 1 – Accidental Death.

Conditions applicable to Dependent Children Education Benefit

1) This Coverage is applicable only to living **Dependent Children**
2) The **Sum Insured** for this Cover is the total claim amount payable for all **Dependent Children**combined
3) The Coverage for this Optional cover terminates on admissibility of Claim equal to the **Sum Insured**

iv. Renewal Premium Benefit

In the event, Claim for **Insured Policy Holder** becomes admissible under Cover 1 – Accidental Death, We will pay the amountequivalent to the Renewal premium of the Coverage for all other **Insured Person** covered in the same policy as mentioned in the Schedule of Coverage on the Policy Schedule.

Conditions applicable to Renewal Premium Benefit

i. Renewal Premium benefit will only be in respect of Coverage under Section 2 – Personal Accident
ii. The Benefit will be payable irrespective of whether Policy is renewed or not.

v. Parental Care Benefit

We will pay the **Sum Insured** towards parental care of **Dependent Parents**, in the event of Claim admissible under Cover 1 – Accidental Death.

Conditions applicable to Parental Care Benefit

1) This Coverage is applicable only to living **Dependent Parents**
2) The **Sum Insured** for this Cover is the total claim amount payable for both **Dependent Parents**combined
3) The Coverage for this Optional cover terminates on admissibility of Claim equal to the **Sum Insured**

vi. Medical Evacuation

We will indemnify the **Insured Person** for Air Ambulance transportation in an airplane or helicopter for **Emergency Care** which requires immediate and rapid ambulance transportation as prescribed by Medical Practitioner, from the site of first occurrence of the **Accident** to the nearest **Hospital**, that ground transportation cannot provide provided Claim is admissible under any of the Cover 1 to 9 of this Section.

Conditions applicable to Medical Evacuation

The Claim under this cover is admissible only once in a **Policy Year** irrespective of number of Claims becoming admissible under any of the Cover 1 to 9 of this Section.

Section 2.B. Exclusions & Waiting Period

A. General Exclusions

I. Specific General Exclusions

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**;

i. The abuse or the consequences of the abuse of tobacco, intoxicants or hallucinogenic substances including all forms of narcotic drugs and alcohol unless prescribed by Medical Practitioner
ii. War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, , civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, **Nuclear, Chemical, Biological attack** or weapons/materials or radiation of any kind
iii. Whilst travelling in aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.
iv. Death or Disability suffered by the **Insured Person** on account of his participation as the driver, co-driver or passenger during trial runs (excluding Test Drives)using a motorized vehicle or bicycle.
v. Death or Disability caused by or arising from or in consequence of or contributed to **Nuclear, Chemical** or **Biological**attack/weapons, material by or arising from or in consequence of or contributed to by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission).
vi. Any **Insured Person** committing or attempting to commit intentional **self-Injury**(except in an attempt to save human life) or suicide while mentally sound or suffering from **Mental illness**
vii. From engaging in or participation in naval, military or air force operation.
viii. **Injury** sustained whilst or as a result of participation as a professional in **Hazardous** or **Adventure sports**
ix. Breach of Law: Expenses for treatment directly arising from or consequent upon any **Insured Person** committing or attempting to commit a breach of law with criminal intent.
x. **Injury** sustained whilst or as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder.
xi. **Injury** sustained whilst on service or on duty with or undergoing training with any military or police force, or militia or paramilitary organisation, notwithstanding that the **Injury** occurred whilst the **Insured Person** was on leave or not in uniform.

B. Exclusions applicable to Cover 3, II – Temporary Total Disablement due to Illness and Cover 5, Emergency Medical Expenses

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

I. Standard Waiting Periods

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

i) **Pre-existing Diseases – 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 36 months of continuous coverage after the date of inception of the first 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 36 months 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 waiting period**- Code – Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with us.
b. This exclusionshall not be applicable for claims arising due to an **Accident**.
c. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of **Sum Insured** increase.
d. 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.
e. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
f. 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.

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

i. Surgical Procedures

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

iii) **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.

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
   b. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
   c. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
ii. **Rest Cure, rehabilitation and respite care**Code – Excl05 – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. **Obesity/Weight control:** Code – Excl06 – Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the doctor
   b. The surgery/procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI)
      i. Greater than or equal to 40 or,
      ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      iii. Obesity related cardiomyopathy
      iv. coronary heart disease
      v. severe sleep apnoea
      vi. 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 removea 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 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.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.Excl14

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

xiii. **Unproven Treatments –** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.Excl16

xiv. **Sterility and Infertility** Code – Excl17 - Expenses related to sterility and infertility. This includes:
   e. Any type of contraception, sterilization
   f. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   g. Gestational Surrogacy
   h. 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 weapons/materials, chemical and biological weapons, radiation of any kind.

ii. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.
iii. Any **Insured Person**'s participation or involvement in naval, military or air force operation.
iv. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").
v. Congenital external diseases, defects or anomalies,
vi. Stem cell harvesting
vii. Investigative treatments for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).
viii. Circumcisions (unless necessitated by **Illness** or **Injury** and forming part of treatment).
ix. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.
x. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
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 etc. Full list of Non-Medical expensesis attached and also available at www.hdfcergo.com.
xiii. The provision or fitting of hearing aids, spectacles or contact lenses.
xiv. 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.
xv. 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.
xxi. Expenses for Artificial limbsand/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com
xvi. Any Claim arising due to Non-disclosure of Pre-existing **Illness** or Material fact as sought to be declared on the Proposal form.

Section 2.C. Claims Procedure Section 2– Personal Accident

1. Notification of a Claim

Procedure	**Cashless Hospitalization**	**Cashless claims for Hospitalizations outside India**	**Reimbursement Claims**
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 Hospitalization.	Within 24 hours of the Emergency 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. Duly completed and signed claim form 2. **Policy/**Certificate Copy 3. First Information Report and Final Police report, wherever is necessary 4. Any other supporting documents as may be required by the Company 5. **Insured Person's** own Indian bank cancelled cheque copy and bank details in attached format.		
Accidental Death	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Death certificate 4. Post mortem if conducted/FSL (Forensic science laboratory)report – To check for drug abuse/intoxication		
Permanent Disablement	1. Medical Practitioner's Report 2. Medico Legal Certificate		

	3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the **Injury**; 4. Disability certificate from a government certified **Medical Practitioner** or government **Hospital** confirming the extent and nature of disability; 5. Original Discharge summary from the **Hospital** Medical reports, case histories, investigation reports,treatmentpapers as applicable. 6. Letter from treating **Medical Practitioner** mentioning the reason and date for disablement and confirming the disablement.
Temporary Total Disablement	1. **Medical Practitioner's** Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the **Injury**; 4. Original Discharge summary from the **Hospital** 5. Medical reports, case histories, investigation reports, treatment papers as applicable. 6. Letter from treating **Medical Practitioner** mentioning the reason and date for disablement and confirming the disablement. And advised days of rest. 7. Leave certificate from the employer (If Employed) 8. Fitness certificate from **Medical practitioner** 9. Insured's own Indian bank cancelled cheque copy and bank details in attached format
Hospital Cash-Accident Only	1. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for **Hospital** cash benefit 2. First consultation letter from treating Medical Practitioner 3. Certificate from treating Medical Practitioner, specifying the duration and etiology 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 5. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.
Broken Bones	1. Medical Practitioner's Report 2. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury; 3. Disability certificate from a government certified Medical Practitioner or government hospital confirming the extent and nature of disability; 4. Original Discharge summary from the hospital 5. Medical reports, case histories, investigation reports, treatment papers as applicable. 6. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 7. Relevant treatment papers clearly mentioning the areas of fracture with their severity.
Burns	1. Attested copy of certificate from treating Medical Practitioner specifying type of burns with percentage of burns 2. Attested copy of FIR. (If any) 3. All X-Ray / Investigation reports and films supporting to disability.
Medical Evacuation	1. Consultation note or Emergency Room's Medical Practitioner medical report 2. Copy of the passport showing the date of entry and exit related to journey (to & fro) from India. 3. All relevant Original Invoices for the expenses incurred towards ambulance facility. 4. A covering letter from claimant mentioning the details of loss.
Emergency Medical Expenses	1. Consultation note or Emergency Room's Medical Practitioner medical report. 2. Relevant treatment papers or Discharge Summary. 3. Copy of the passport showing the date of entry and exit related to journey (to & fro) from India. 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 5. All relevant Original Invoices for the expenses incurred.
Dependent Child Education Benefit	1. Consultation Note OR Emergency Room's Medical Practitioner medical report OR 2. Relevant Treatment Papers OR Discharge Summary. . 3. Letter from treating Medical Practitioner, mentioning the cause of death if death occurred after a long period from the date of incident. 4. Disability certificate from a government certified Medical Practitioner or government hospital confirming the extent and nature of disability; 5. Death certificate 6. Final police investigation report

	7. Post-mortem Report or Coroner's Report 8. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable.
Chauffeur Benefit	1. **Medical Practitioner's** Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the **Injury**; 4. Original Discharge summary from the **Hospital** 5. Medical reports, case histories, investigation reports, treatment papers as applicable. 6. Letter from treating **Medical Practitioner** mentioning the reason and date for disablement and confirming the disablement. 7. Original invocies of transport
Particulars to be provided for pre-authorization	1. Policy Number 2. Name of the **Insured person**(s) named in the Policy schedule availing treatment 3. Nature of disease/**Illness/Injury** 4. Name and address of the attending **Medical Practitioner/Hospital** 5. Date of admission & probable date of discharge 6. Approximate Claim Expenses 7.
	Any other relevant information as required
Process for obtaining Pre-Authorization	i. If the particulars are not provided in full or are insufficient for **Us** to consider the request, We will request additional information or documentation ii. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, **We** may; Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or Reject the request for pre-authorization specifying reasons for the rejection.
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. 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 GIC or certificate from hospital authorities providing facilities available including number of beds.
v. Original Discharge Card / Day Care Summary / Transfer Summary
vi. Original final hospital bill with all original deposit and final payment receipt and refund receipt(s), if advance amount refunded
vii. Original 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 original diagnostic reports (including imaging and laboratory) along with prescription by **Medical Practitioner** and invoice / bill with receipt from diagnostic centre
x. All original 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. Original 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 Proposer carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Proposer.
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 proposer, the same document reuqirement would be for nominee/legal heir of proposer(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility

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

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, **We** shall offer within a period of 30 days a settlement of the claim to the insured.
iii. However, where the circumstances of a claim warrant an investigation, **We** will initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, **We** will settle the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay in payment of Claim beyond stipulated period, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
v. If **We**, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.
vi. 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.
vii. **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.

Section C – General Conditions

I. Standard General Clauses

1. 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
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.

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. Multiple Policies (Applicable to Section 1 - Health)

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

4. 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.

5. 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.

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. 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 have 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**.

8. 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.

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.

9. Portability (Applicable to Section 1 – Health)

The **Insured Person** will have the option to port the Policy to other insurers by applying to such **Insurer** to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

10. Migration(Applicable to Section 1 – Health)

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

For Detailed Guidelines on Migration, kindly refer the link

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

11. Premium Payment in Instalments

If the **Insured Person** has opted for Payment of Premium on an installment basis i.e. Yearly, 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 installment premium due for the **Policy**.

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

i. 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).
ii. 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 installment premium is not paid on due date.
iv. In case of installment 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.

Instalment Premium payment through Auto Debit/ECS Facility

i. If Option of Premium payment by Installment is opted through auto Debit/ECS facility, a separate authorization form shall be submitted by Insured Person where Premium to be debited at a chosen frequency will be mentioned upfront
ii. Where there is a change either in the terms and conditions of the Coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh
iii. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable
iv. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode

12. 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.

13. 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.

14. Claim Settlement (Provision for Penal Interest) – Applicable to Section 1 - Health

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents

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

iii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the **Policyholder** from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.

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

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

vi. If **We**, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.

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

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

15. 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. 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.

ii. 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

iii. 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

iv. 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.

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16. **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**.

17. Grievance Redressal Procedure

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

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

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at cgo@hdfcergo.com

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

Contact Points	**First Contact Point**	**Escalation level 1**	**Escalation level 2**
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

i. If Insured person is not satisfied with the redressal of grievance through above methods**,** the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

II. Specific General Terms & Clauses

1. Geography

Section 1- Health

This Policy provides coverage in India, except under the policies with Emergency Worldwide Coverage and Overseas treatment as may be specified in the on the Schedule of Coverage in the Policy Schedule.

Section 2 – Personal Accident

This Policy provides coverage Worldwide, except under the covers specifically mentioning as covered in India only under the terms and conditions.

2. 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. However, increase or decrease of discount in Medical Underwriting loading is subject to terms mentioned under **Section 1.III. 3 – Health Incentives**
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.

3. Non-Disclosure or Misrepresentation

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

   a) cancelled ab initio from the inception date or the **Renewal** date (as the case may be), or the Policy may be modified by Us at **Our** sole discretion, upon 15-day notice by sending an endorsement to **Your** address shown in the Schedule and
   b) the claim under such Policy if any, shall be prejudiced.

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

   a) Permanently exclude the disease/condition and continue with the Policy
   b) Incorporate additional waiting period of not exceeding 3 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 3 i** above.

4. Grace Period

i. A **Grace Period** of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during **Grace Period**will not be covered and will be treated as **Pre-existing diseases**.
ii. Policies for which Premium is received after the **Grace Period** shall be issued as a fresh policy.
iii. For Policies on instalment basis, Grace Period is available as given below.
iv. 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).

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

5. 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 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

x. Change in Age/date of birth
xi. Change in Height, weight
xii. Addition of Insured Person (New Born Baby or newly wedded spouse)
xiii. Deletion of Insured Person on death or Marital separation
xiv. Any other financial endorsement

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

6. Premium Tier (Applicable to Section 1 only)

For the purpose of policy issuance, the premium will be computed basis the city of residence provided by the**Insured Person** in the proposal form. Classification of cities would be as under:

- **Tier 1a:** Delhi and NCR region

- **Tier 1b:** Mumbai, Mumbai Suburban and Navi Mumbai, Pune, Surat, Ahmedabad, Vadodara
- **Tier 2:** Rest of India

Conditions:

i. On payment of Tier 1a premiums, **Insured Person** can avail treatment all over India without any **co-payment**.
ii. On payment of Tier 1b premium, **Insured Person** can avail treatment at Tier1b cities and Tier 2 cities without any **Co-Payment**. However,if Insured Person availsa treatment in Tier 1a cities, 20% **Co-Payment** shall be applicable on admissible claim amount.
iii. On payment of Tier 2 premium, **Insured Person** can avail treatment at Tier 2 cities without any **Co-Payment.** However,if**I**nsuredPerson availsa treatment in Tier 1a or Tier1b cities, 20% **Co-Payment** shall be applicable on admissible claim amount.
iv. **Co-Payment** under ii and iii above will not be applied If **Insured Person** opts for **Hospitalization** with **Room Rent** up to Rs. 5,000 per day or on **Hospitalization** for **Medically Necessary** treatment following an **Accident**

7. Disclaimer applicable to HDFC ERGO Mobile Appand associated services

It is agreed and understood that Our **HDFC ERGO Mobile App**and Wellness services intention is not to provide specific medical advice but rather to provide users with information to better understand their health and their diagnosed disorders. The information is not a substitute for professional medical care by a qualified doctor or other health care professional.

The information provided is general in nature and is not specific to you. You must never rely on any information obtained using this app for any medical diagnosis or recommendation for medical treatment or as an alternative to medical advice from your physician or other professional healthcare provider. If you think you may be suffering from any medical condition you should seek immediate medical attention.

Reliance on any information on this App is solely at your own risk. HDFC EGRO General Insurance Company Limited do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations, any decision made or action taken or not taken in reliance upon the information.

8. Any Benefit/Indemnity payable by the Company, if any, in case of Your loss of life is payable as defined in the Policy Schedule by default to the assignee declared by You; indemnity is payable to Your estate. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of the payment.

9. 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 D – Other Terms & Conditions

Contact Us

	Within India	**Outside India**
Claim Intimation:	Service No. 022-62346234 / 0120-62346234 **Email**:healthclaims@hdfcergo.com	**Contact us:** 800 08250825 **Global contact No** : +800 08250825 (accessible from locations outside India only) **Landline no (Chargeable)** : 0120-4507250 **Email**travelclaims@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	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, Andheri Kurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

Ombudsman Details

S.No	Office Details	Jurisdiction of Office (Union Territory,District)
1	**AHMEDABAD** Shri Collu Vikas Rao Insurance Ombudsman 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.
2	**BENGALURU** Mr Vipin Anand Insurance Ombudsman 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.
3	**BHOPAL** Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202: Email : bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.

4	**BHUBANESWAR** Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
5	**CHANDIGARH** Mr Atul Jerath Insurance Ombudsman 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.
6	**CHENNAI** Shri Somnath Ghosh Insurance Ombudsman 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).
7	**DELHI** Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
8	**GUWAHATI** Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Shri N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

10	**JAIPUR** Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
11	**KOCHI** Shri G. Radhakrishnan Insurance Ombudsman 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.
12	**KOLKATA** Ms Kiran Sahdev Insurance Ombudsman 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.
13	**LUCKNOW** Shri. Atul Sahai Insurance Ombudsman 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.
14	**MUMBAI** Mr Vipin Anand Insurance Ombudsman 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	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

15	**NOIDA** Shri Bimbadhar Pradhan Insurance Ombudsman 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.
16	**PATNA** Ms Susmita Mukherjee Insurance Ombudsman 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.
17	**PUNE** Shri Sunil Jain Insurance Ombudsman 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	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Annexure I - List of Non-Medical Expenses

S. No.	Item	S. No.	Item

1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT

30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY