ENERGY

Contents

Preamble

This Policy offers cover to individuals with Type 2 Diabetes Mellitus, Impaired Fasting Glucose (IFG), Impaired Glucose Tolerance (IGT), Type 1 diabetes and/or Hypertension. The insurance cover is subject to the terms, conditions and exclusions of this Policy, your payment of premium and realization thereof by us and your statements in the proposal form which is the basis of this Policy.

The insured person will be covered upto the Sum Insured limit under this policy.

Section A: Definitions

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

Standard Definitions

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

Def. 2. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Def. 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 centre which is registered with the local authorities, wherever applicable and having facilities for carrying

out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner*(s) on day care basis without in-patient services and must comply with all the following criterion:

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

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

Def. 8. **Congenital Anomaly** An external congenital anomaly refers to a condition(s) which is present since birth, in the visible and accessible parts of the body, and which is abnormal in reference to form, structure or position.

a) Internal Congenital Anomaly
Which is not in the visible and accessible parts o f the body is called Internal Congenital Anomaly
b) External Congenital Anomaly
Which is in the visible and accessible parts o f the body is called External Congenital Anomaly.

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 sickness and / or injuries or a medical set up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

i) Has qualified nursing staff under its employment
ii) Has qualified medical practitioner (s) in charge
iii) Has a 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** means medical treatment, and/or surgical procedure which is:
i) Undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hrs because of technological advancement, and
ii) Which would have otherwise required hospitalization of more than 24 hours.

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

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

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

Def. 14. **Emergency Care** means management for an Illness or injury 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. 15. **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. 16. **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 & Regulations) 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:

i. Has qualified nursing staff under its employment round the clock,
ii. Has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and atleast 15 in-patient beds in all other places,
iii. Has qualified Medical Practitioner(s) in charge round the clock,
iv. Has a fully equipped operation theatre of its own where surgical procedures are carried out,
v. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 17. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum of 24 In patient care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

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

i) Acute Condition means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

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

Def. 19. **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. 20. **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. 21. **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. 22. **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 intensivist charges.

Def. 23. **Material Facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 24. **Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium.

Def. 25. **Maternity Expense** means

i) Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean sections incurred during hospitalisation)

ii) Expenses towards lawful medical termination of pregnancy during policy period

Def. 26. **Medical Advise** means any consultation or advise 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 doctors in the same locality would have charged for the same medical treatment

Def. 28. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

- Is required for the medical management of the Illness or injury suffered by the Insured Person;

- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
- Must have been prescribed by a Medical Practitioner.
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 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.

Def. 30. **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. 31. **Network Provider** means Hospitals, or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

Def. 32. **Non Network Provider** means any hospital, day care centre or other provider that is not part of the Network.

Def. 33. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 34. **OPD treatment** means the treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient

Def. 35. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

Def. 36. **Pre- Hospitalisation Medical Expenses** means medical expenses incurred during predefined 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. 37. **Post -Hospitalisation Medical Expenses** means medical expenses incurred during predefined 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. 38. **Pre-existing Diseases** 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. 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. **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services by comparable providers, taking into account the nature of illness/ injury involved.

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. **Renewal m**eans 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. 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 of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 44. **Unproven/Experimental treatment** is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven**.**

Specific Definitions

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

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

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

Def. 4. **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. 5. **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 6. **Bank Rate** shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 7. **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. 8. **Commencement Date** means the commencement date of this Policy as specified in the Schedule

Def. 9. **Contribution** means essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion

Def. 10. **Hypertension is** defined as a repeatedly elevated blood pressure exceeding 140 over 90 mmHg i.e. a systolic pressure above 140 with a diastolic pressure above 90. (As per JNC 7 guidelines seventh report of the Joint National Committee).

Def. 11. **Impaired Fasting Glucose (IFG)** is impaired level of glucose, a condition under which a person has a plasma glucose values between 110 and 125 mg/dl after overnight fasting.

Def. 12. **Impaired Glucose Tolerance (IGT)** is a pre-diabetic state of hyperglycemia (Elevated blood sugar) where 2 hours after 75 gm oral glucose tolerance test the plasma glucose level is between 140 to 199 mg/dl

Def. 13. **Insured Person means t**he person named in the Schedule.

Def. 14. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure I and the Schedule (as the same may be amended from time to time).

Def. 15. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 16. **Sum Insured** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Def. 17. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 18. **Type 1 Diabetes** also called juvenile diabetes indicates a condition in which Beta cell of pancreas are destroyed wherein insulin is required for survival.

Def. 19. **Type 2 Diabetes** also called maturity onset diabetes indicates a condition which is characterized by either insulin resistance or relative deficiency of insulin secretion usually present at the time of type II diabetes is clinically manifested.

Def. 20. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited.

Def. 21. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Specific Definitions

Section B. Benefits

The following benefits are available to the Insured Person who suffers an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or a treatment defined as a Day Care Procedure.

I. Hospitalisation Covers

We will cover the Medical Expenses for:	**We will not cover treatment, costs or expenses for*:** *The following exclusions apply in addition to the waiting periods and general exclusions specified in section C
• **In-Patient Treatment** Treatment costs where Insured Person has to stay in a Hospital for more than 24 hours. This includes: • Hospital room rent or boarding • Nursing • Intensive Care Unit • Medical Practitioners (Fees) • Anaesthesia • Blood • Oxygen • Operation theatre • Surgical appliances • Medicines, drugs & consumables • Diagnostic procedures • Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure Note pertaining specifically to AYUSH Treatments only: Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.	Treatment availed outside India Treatment at a healthcare facility which is NOT a Hospital. Treatment for which hospitalization is not necessary
1. **Pre-Hospitalization Medical expenses** for consultations, investigations and medicines incurred upto 30 days before Hospitalisation. 2. **Post-Hospitalization Medical expenses** for consultations, investigations	1. Claims which have NOT been admitted under I.1) and I.4). 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required. 3. Expenses not related to the admission and not incidental to the treatment for which the admission has taken place

Important terms You should know

Sum Insured means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

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

Day Care treatments means those medical treatment.

and medicines incurred upto 60 days after discharge from Hospitalisation.	
3. **Day Care Procedures** Medical treatment, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre for less than 24 hours because of technological advancement, which would have otherwise required a hospitalisation of more than 24 hours.	Out-Patient Treatment Admission for the purpose of only administration of any drug/medication/formulation other than cancer chemotherapy. Treatment at a healthcare facility which is NOT a Hospital
4. **Organ Donor** Medical treatment of the organ donor for harvesting the organ i.e. cost of surgery to remove organs from a donor in the case of transplant surgery	1. Claims which have NOT been admitted under I.1). 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
5. **Ambulance Cover** Expenses incurred on an ambulance in case of an emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under I.1) and I.4). 2. Ambulance services of NON registered healthcare or ambulance service provider.
6. **Shared Accommodation Benefit** If the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital, the exclusion related to non-medical expenses shall be waived.	
II. Other Benefits	
1. **Restore benefit** Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, cumulative bonus and Restore sum insured) will be available to the insured person for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the cumulative	

bonus (if applicable). Conditions for Restore benefit: a. The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section I. b. The Sum Insured will be restored only once in a Policy Year. c. If the restored sum insured is not utilised in a policy year, it shall not be carried forward to any subsequent policy year.	
2. **HbA1C Checkup Benefit** Under this benefit, we will reimburse an amount of up to INR 750 on an each claim towards the expenses of HbA1C checkup on submission of original payment receipt to us subject to 1) The date of tests should be in the Policy period. 2) A maximum of two claims can be made in a Policy year. 3) A minimum of 3 months gap should be there between the two tests 4) In Gold variant, HbA1C checkups done as part of wellness benefit (Section III.1 of Policy Wordings) will not be considered for this benefit.	

III. Renewal Benefits

1. **Wellness Programme for Diabetes and Hypertension**

Variant1. Silver Plan

a) To avail Wellness Benefit You may choose to undergo a medical check-up twice in a Policy Year as per grid below at a diagnostic center which is approved by Us. Please note that the costs incurred for these tests will have to be borne by You.

Medical check-up reports have to be submitted to Us in time as per below defined timelines. Any reports submitted after these timelines will not be accepted/considered for wellness benefit.

Medical Check-up Grid:

Period	**Diagnostic Tests**
Half yearly check-up	HbA1c, Blood pressure Monitoring, BMI, Diabetologist/Cardiologist Consultation
Annual check-up	HbA1c, SMA 12, Total Cholesterol : HDL Cholesterol, ECG, Blood pressure Monitoring, BMI, Diabetologist/ General Practitioner Consultation

SMA 12 - FBS, Total Cholesterol, Creatinine, High-density lipoprotein (HDL) , Low-density lipoprotein (LDL), Triglycerides (TG), Total Protein, Serum Albumin**,** Gamma-glutamyltransferase (GGT), serum glutamic oxaloacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT), Billirubin

Timelines for submitting the Medical Check-up reports:

Medical Check-up	Reports should be submitted in:
Half yearly check-up	4^{th} or 5^{th} months of the policy year
Annual check-up	8^{th} or 9^{th} months of the policy year

b) Based on medical check-up results incentive points would be calculated as per table below, this shall be the basis for deciding appropriate level of reduction in renewal premiums and the renewal incentive.

Examination Type	Reading	Points
HbA1c (%) – Half Yearly Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 – 8.00	1
HbA1c (%) – Annual Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 - 8.00	1
Blood Pressure – Half Yearly Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Blood Pressure - Annual Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1

Body Mass Index (BMI)	18.00 – 23.00	5
	23.01 – 27.49	2
	27.50 – 34	1
Total Cholesterol : HDL Cholesterol ratio	upto 4.0	2
	4.01 to 5.00	1
Diagnostic test undertaken	Both (Annual + Half Yearly)	3
	Either (Annual or Half Yearly)	1
Diabetologist consultation/General Practitioner	One Visit	2

c) On the completion of all the above stated medical check- ups during the policy year and based on the findings, We may decide to
   a. continue with the published premium and loading (if applicable at the time of inception), or
   b. charge a reduced premium after applying Wellness discount if earned based on the incentive points mentioned in the above table

Variant 2: Gold Plan

a) We will conduct Your medical check-up twice in a Policy Year as per grid below.

Period	**Diagnostic Tests**
Half yearly check-up	HbA1c, Blood pressure Monitoring, BMI, Diabetologist/ Consultation
Annual check-up	HbA1c, SMA 12, Total Cholesterol : HDL Cholesterol, ECG, Blood pressure Monitoring, BMI, Diabetologist Consultation General Practitioner

SMA 12 - FBS, Total Cholesterol, Creatinine, High-density lipoprotein (HDL) , Low-density lipoprotein (LDL), Triglycerides (TG), Total Protein, Serum Albumin**,** Gamma-glutamyltransferase (GGT), serum glutamic oxaloacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT), Billirubin

b) The medical check-up shall be conducted by empanelled medical centre and the cost of the same shall be borne by Us. If You choose to undertake medical check-up from a diagnostic center which is approved by Us, We will reimburse upto Rs.2000/- against actual diagnostic bill and You shall provide Us with medical check-up reports in time during Policy Period as per below defined timelines. Any reports submitted after these timelines will not be accepted/considered for wellness benefit.

Timelines for submitting the Medical Check-up reports:

Medical Check-up	Reports should be submitted in:
Half yearly check-up	4^{th} or 5^{th} months of the policy year
Annual check-up	8^{th} or 9^{th} months of the policy year

c) We will not reimburse any amount in lieu of the medical check-up, if You choose not to undergo any of the medical checkups.

d) We shall obtain and retain Your medical reports. A copy of the medical check-up reports shall be sent to You for your reference.

e) Based on medical check-up results incentive points would be calculated as per table below, this shall be the basis for deciding appropriate level of reduction in renewal premiums.

Examination Type	Reading	Points
HbA1c (%) – Half Yearly Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 – 8.00	1
HbA1c (%) – Annual Examination	Upto 5.99	5
	6.00 - 6.50	2
	6.51 - 8.00	1
Blood Pressure – Half Yearly Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Blood Pressure - Annual Examination	110-120/70-80	5
	121-139/80-89	2
	140-150/90-100	1
Body Mass Index (BMI)	18.00 – 23.00	5
	23.01 – 27.49	2
	27.50 - 34	1
Total Cholesterol : HDL Cholesterol ratio	upto 4.0	2
	4.01 to 5.00	1
Diagnostic test undertaken	Both (Annual + Half Yearly)	3
	Either (Annual or Half Yearly)	1
Diabetologist consultation/General Practitioner	One Visit	2

f) On the completion of all the above stated medical check- ups during the policy year and based on the findings, We may decide to

vi. continue with the published premium and loading (if applicable at the time of inception), or

vii. charge a reduced premium after applying Wellness discount if earned based on the incentive points mentioned in the above table

Wellness Benefit

The appropriate level of discount in renewal premium and renewal incentive would be computed as per below table based on the incentive points calculated as per medical checkup results. Our decision in this regard shall be final and binding on the policyholder.

Points Earned	**Discount**	**Renewal Incentive**

29-32	25% discount on renewal premium	Reimbursement upto 25% of renewal premium towards expenses incurred on health care.
25-28	20% discount on renewal premium	Reimbursement upto 20% of renewal premium towards expenses incurred on health care.
16-24	10% discount on renewal premium	Reimbursement upto 10% of renewal premium towards expenses incurred on health care
8-15	5% discount on renewal premium	Reimbursement upto 5% of renewal premium towards expenses incurred on health care
Less than 8	No discount	No Reward

i. Reimbursement under renewal incentive can be claimed once during the Policy Period on submission of original bills or proof of such expenses incurred during the Policy Period on the health of the Insured Person.
ii. Reimbursement can be claimed for the below mentioned health care expenses for Insured Person under the Policy
    1. Consultation charges
    2. Medicines and drugs
    3. Diagnostic expenses
    4. Dental expenses
    5. Other miscellaneous Medical Expenses not covered under any medical insurance
iii. We will not carry forward any un-claimed amount on subsequent renewal of policy with Us.

a) The revised premium and renewal incentive as per clause a) above shall be applicable only for the following Policy Year onwards and shall be reassessed at the end of each Policy Year.

2. **Cumulative Bonus**

On Renewal of this Policy with the Company without a break, a sum equal to 10% 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) The maximum multiplier bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.
ii) The applicable Cumulative Bonus shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy
iii) Portability/migration benefit will be offered to the extent of sum of previous sum insured and accrued multiplier bonus, portability/migration benefit shall not apply to any other additional increased Sum Insured.
iv) 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.

Section C. Exclusions

1. Standard Waiting Period

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

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

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

Sl No	**Organ / Organ System**	**Illness/diagnoses and any other related complications (irrespective of treatments medical or surgical)**	**Surgeries/procedures (irrespective of any illness / diagnosis other than cancers)**
a.	Ear, Nose and Throat (ENT)	▪ Sinusitis ▪ Rhinitis ▪ Tonsillitis	▪ Adenoidectomy ▪ Mastoidectomy ▪ Tonsillectomy ▪ Tympanoplasty ▪ Surgery for nasal septum deviation ▪ Surgery for Turbinate hypertrophy ▪ Nasal concha resection ▪ Nasal polypectomy
b.	Gynaecological	▪ cysts, polyps including breast lumps ▪ Polycystic ovarian disease ▪ Fibromyoma ▪ Adenomyosis ▪ Endometriosis ▪ Prolapsed Uterus	▪ Hysterectomy ▪
c.	Orthopaedic	▪ Non infective arthritis ▪ Gout and Rheumatism ▪ Osteoarthritis ▪ Ligament, Tendon and Meniscal tear ▪ Prolapsed inter vertebral disk	▪ Joint replacement surgeries ▪
d.	Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus	• Cholecystectomy ▪ Surgery of hernia

		• Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess ▪ Rectal Prolapse	
e.	Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate ▪ Varicocele	• Surgery on prostate ▪ Surgery for Hydrocele/ Rectocele
f.	Eye	▪ Cataract ▪ Retinal detachment ▪ Glaucoma	▪
g.	Others	▪	▪ Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs whether or not described above)	▪ Benign tumors of Non infectious etiologye.	▪

ii) **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 24 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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

Any condition or illness, complication or ailment arising out of or connected to the below mentioned conditions shall not be considered as part of this waiting period.

a. Type 2 Diabetes Mellitus
b. Impaired Fasting Glucose (IFG)
c. Impaired Glucose Tolerance (IGT)
d. Type 1 Diabetes
e. Hypertension

Important terms You should know

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

i. That is/are diagnosed by a physician within months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. For which **Medical advice** or treatment was recommended by, or received from, a physician within months prior to the effective date of the policy or its reinstatement.

2. *Standard Exclusions*

I. Standard Medical Exclusions

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

a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.

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

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

c. 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.

d. 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:

e. Surgery to be conducted is upon the advice of the doctor

f. The surgery/procedure conducted should be supported by clinical protocols

g. The member has to be 18 years of age or older and

h. 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) **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.

vii) **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.

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

ix) 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

x) 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

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

xii) **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

xiii) **Sterility and Infertility –**Code – Excl17 -Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
j. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
k. Gestational Surrogacy
l. Reversal of sterilization

xiv) **Maternity:**Code – Excl18

m. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
n. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

II. Standard Non Medical Exclusions

i) 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.

ii) 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.

3. Specific Exclusions

We will not pay for any claim arising from:

Non Medical Exclusions	i) War or similar situations: Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. ii) Intentional self-injury or attempted suicide while sane or insane.
Medical Exclusions	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 sub luxation, diagnosis and treatment by manipulation of the skeletal

	structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities). 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 and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com. xiii) Treatment taken on Outpatient basis xiv) The provision or fitting of hearing aids, spectacles or contact lenses. xv) Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, Optometric therapy. xvi) Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription. xvii) Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively). Prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com xviii) Any Claim arising due to Non-disclosure of Pre-existing **Illness** or Material fact as sought to be declared on the Proposal form. xix) Prosthetic and other devices which are self-detachable /removable without surgery involving anaesthesia xx) Treatment availed outside India xxi) Treatment at a healthcare facility which is NOT a Hospital. xxii) Any non-allopathic treatment except to the extent of coverage provided for under 'In-patient Hospitalization treatment' cover xxiii) Dental treatment and surgery of any kind, unless requiring Hospitalisation. xxiv) Expense related to pancreatic islet transplantation. xxv) Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. xxvi) Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. xxvii) Admission for administration of Intraarticular or Intra-lesional injections, S u p p l e m e n t a r y m e d i c a t i o n s l i ke Zolendronic

	acid (Trade name Zometa, Reclast, etc.) or IV immunoglobulin infusion xxviii) Any specific time bound exclusion(s) not exceeding 36 months applied by Us and specified in the Schedule and accepted by the insured.

Section D. General Terms & Clauses

1. Standard General Terms

1. 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.

2. Premium payment in Instalments

If the Insured Person has opted for payment of Premium on an instalment 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):

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

Options	Instalment Premium Option	Grace Period applicable
Option 1	Multi-Year / Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 Days

b. 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).
c. 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
d. No interest will be charged If the instalment premium is not paid on due date
e. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled
f. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
g. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

3. 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.

4. 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.

5. Moratorium Period

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

6. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his

knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Multiple Policies

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

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. The Company shall endeavor to give notice for Renewal.
ii. 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.
iii. 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.
iv. No loading shall apply on renewals based on individual claims experience
v. 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.
vi. Renewal premium due can be paid prior to the due date as per norms set out by the Company.
i.

9. Redressal of Grievance

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/

10. 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.

11. 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.

12. Portability

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

For Detailed Guidelines on Portability, kindly refer the link

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

13. Migration

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

i.

For Detailed Guidelines on Migration, kindly refer the link

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

14. 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;

15. Nomination:

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

16. Claim Settlement (Provision of Penal Interest):

(1) 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.
(2) 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.
(3) 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.
(4) 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.

17. Cancellation

i. The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.
ii. Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

iii. The Company may cancel the Policy at any time on grounds of 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

iv. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s

v. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

2. *Specific General Terms*

1. Policy Term

The premium for the policy will remain the same for the Policy Period mentioned in the policy schedule. The Policy will be issued for a period of 1yearand the Sum Insured & benefits will be applicable on Policy Year basis.

2. Geography

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

3. Insured Person

Any person named as Insured Person in the Schedule shall be covered under this Policy.

If an Insured Person dies, the Policy would automatically cease upon Us receiving all relevant particulars in this regard. We will return a rateable part of the premium received IF AND ONLY IF there are no claims reported under the Policy.

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

4. Loadings

We may apply a risk loading on the premium payable (based on the declarations made in the proposal form and the health status of the persons proposed for insurance) at the Commencement Date or on any renewal of the Policy with Us or on the receipt of a request for enhancing the Sum Insured. The maximum risk loading applicable for an individual will not exceed 100% per diagnosis / medical condition and an overall risk loading of 150% per individual.

We will send You the applicable risk loading or exclusion in writing. You shall give Us Your consent and the additional premium (if any), within 7 days of the issuance of Our letter. If You neither accept Our letter nor revert to Us within 7 days, We will cancel Your application and refund the premium paid within the next 7 days.. We will issue Policy only after getting Your consent.

Pl Note:
The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section C1-i &ii, above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

5. Notification of Claim

	Treatment, Consultation or Procedure:	**We or Our TPA must be informed:**
	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation.	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency.	Within 24 hours of the Insured Person's admission to Hospital.

6. Cashless Service:

	Treatment, Consultation or Procedure:	**Treatment, Consultation or Procedure Taken at:**	**Cashless Service:**	**Notice period for the Insured Person to take advantage of the cashless service*:** *Written notice must be accompanied by full particulars.
	Any planned treatment, consultation or procedure for which a claim may be made.	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
	Any treatment, consultation or procedure for which a claim may be made taken in an Emergency.	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours of the start of the Insured Person's Hospitalisation.

7. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with any documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the either of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include the following. Please note that in case of a non-

disclosure or/and a fraud suspicion we may ask for additional documentation/reports which are not listed below.

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

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

9. Claims Payment

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
ii. We will only make payment to Insured Person under this Policy. In the event of Insured Person's death, We will make payment to the Nominee (as named in the Schedule/Certificate of Insurance) Payments under this Policy shall only be made in Indian Rupees within India.
iii. The assignment of benefits of the policy shall be subject to applicable law.
iv. Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability

directly to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an emergency.

10. Non-Disclosure or Misrepresentation

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

a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us at **Our** sole discretion, upon 15 day notice by sending an endorsement to **Your** address shown in the Schedule and

b) the claim under such Policy if any, shall be prejudiced

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

a) Permanently exclude the disease/condition and continue with the Policy
b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

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

11. **Endorsements**

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

12. **Change of Policyholder**

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

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

13. **Notices**

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

i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement
ii) Us, shall be delivered to Our address specified in the Schedule.

No insurance agents, brokers, other person or entity is authorised to receive any notice on Our behalf unless explicitly stated in writing by Us.

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

15. **Co-Payment**

If opted and mentioned on the Policy Schedule that a Co-payment is effective, and a claim has been admitted under Section 1 then, the insured person shall bear 20% of the eligible claim amount payable under the Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

Section E. Other Terms & Conditions

Contact us

	Within India	**Outside India**
Claim Intimation:	**Contact us** :022 6234 6234 / 0120 6234 6234 **Phone (UAN)** :1860 2000 700 (Local charges applicable) **Fax (UAN)** : 1860 2000 600 (Local charges applicable) **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, Sector 62 Noida – 0120 398 8360	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, AndheriKurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

Ombudsman Details

S.No	Office Details	Jurisdiction of Office (Union Territory,District)
1	**AHMEDABAD** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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** 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).

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

Annexure 1 – List of Non-Medical Expenses

S.No	List of Non Medical Expenses
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS

8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSp|TAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HTNGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT

48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Schedule of Benefits

Gold Plan:

Sum Insured – (Rs. In Lakhs)	2.00, 3.00, 5.00, 10.00, 20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered
1 b) Pre-hospitalization	Covered
1 c) Post-hospitalization	Covered
1 d) Day Care Procedures	Covered
1 e) Organ Donor	Covered
1 f) Ambulance Cover	Upto Rs.2000 per hospitalisation
1 g) Shared Accommodation Benefit	Covered
1 h) HbA1C Checkup Benefit	Covered
1 i) Restore Benefit	Covered
1 j) Wellness Benefit	Covered

Silver Plan:

Sum Insured – (Rs. In Lakhs)	2.00, 3.00, 5.00, 10.00, 20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered
1 b) Pre-hospitalization	Covered
1 c) Post-hospitalization	Covered
1 d) Day Care Procedures	Covered
1 e) Organ Donor	Covered
1 f) Ambulance Cover	Upto Rs.2000 per hospitalisation
1 g) Shared Accommodation Benefit	Covered
1 h) HbA1C Checkup Benefit	Covered
1 i) Restore Benefit	Covered
1 j) Wellness Benefit	Covered