HDFC ERGO General Insurance Company Limited

Policy Wordings

my:health Suraksha

CONTENTS

PREAMBLE

We will provide insurance cover to the Insured Person(s) under this Policy upto Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule.

This Policy is subject to Your statements in respect of all the Insured Persons in Proposal form, declaration and/or medical reports, payment of premium and the terms and conditions of this Policy.

DEFINITIONS

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

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

Standard Definitions

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 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 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 medical treatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and

ii) which would have otherwise required Hospitalization of more than 24 hours,

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

Def. 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 which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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 a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.

Def. 18. Hospital means any institution established for In-patient Care and Day Care Treatment ofIllness 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 ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

2. it needs ongoing 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. 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. 23. 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. 24. 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. 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. Major Illness means:

Standard Definitions:

1. Cancer of specified severity

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

The following are excluded:

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown 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 tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Open Chest CABG

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

II. The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

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

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

b. New characteristic electrocardiogram changes

c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

a. Other acute Coronary Syndromes

b. Any type of angina pectoris

c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. Kidney failure requiring regular dialysis

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.

5. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

a. One of the following human organs: lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ,

b. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

6. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

7. Permanent Paralysis of Limbs

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

8. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.

b. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

a. Transient ischemic attacks (TIA)
b. Traumatic injury of the brain
c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

9. **Primary (Idiopathic) Pulmonary Hypertension**

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

10. 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.

Specific Definitions:

11. Surgery of Aorta

The actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta is excluded.

Def. 27. Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 28. 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. 29. 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. 30. 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 for mental illnesses means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;

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. 31. Migration means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def. 32. Newborn Baby means baby born during the Policy Period and is Aged up to 90 days

Def. 33. 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. 34. Non Network means any Hospital, Day Care Centre or other provider that is not part of the Network

Def. 35. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 36. 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. 37. Portability means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def. 38. Pre-existing disease means any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician within 48 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 48 months prior to the effective date of the policy or its reinstatement.

Def. 39. Pre-hospitalization Medical Expenses meansMedical Expenses incurred during pre-defined number of dayspreceding 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. 40. 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 M**edical 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. 41. 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. 42. 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. 43. Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the AssociatedMedical Expenses

Def. 44. Reasonable and Customary Chargesmeans 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. 45. Surgery or Surgical Proceduremeans 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. 46. 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.

Specific Definitions

Def. 1. Adventurous/Hazardous Sports means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment

or as part of his Profession whether he / she is trained or not.

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

Def. 3. Alternative treatments means forms of treatments other than treatment "Allopathic" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Def. 4. Associated Medical Expenses means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def. 5. 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. 6. Commencement Date means the commencement date of the Policy as specified in the Policy Schedule.

Def. 7. 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 parents in law

Def. 8. 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.

Def. 9. Insured Person means the persons named in the Policy Schedule and insured under the Policy.

Def. 10. 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. 11. 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. 12. 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. 13. Non-Medical Expenses – Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergo.com

Def. 14. HDFC ERGO Mobile App isproprietary App of HDFC ERGO General Insurance Company. With this App 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 SubmitYour 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. 15. Surrogacy means a practice whereby one woman bears and gives birth to a child for an intending couple with the intention of handing over such child to the intending couple after the birth

Def. 16. Surrogate mother means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as provided in sub-clause (b) of clause (iii) of Section 4 of the 'The Surrogacy (Regulation) Act, 2021'

Def. 17. Oocyte means naturally ovulating oocyte in the female genetic tract.

Def. 18. 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. 19. 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. 20. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule

Def. 21. Policy Holder means Person who has proposed the Policy and in whose name the Policy is issued

Def. 22. 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 Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 23. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 24. 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. 25. We/Our/Us means the HDFC ERGO General Insurance Company Limited

Def. 26. You/Your/Policyholder means the person named in the Policy Schedule who is insured under the Policy or has proposed and concluded this Policywith Us.

SECTION B: BENEFITS

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. The payment is subject to Sum Insured and limits including Cumulative Bonus if applicable as specified on the Schedule of Coverage in the Policy Schedule. Subject to otherwise terms and conditions of the Policy.

I. Hospitalization Cover

1. Medical Expenses

i. Room rent, boarding and Nursing charges
ii. Intensive Care Unit charges
iii. Consultation fees
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
v. Medicines, drugs and consumables
vi. Diagnostic procedures
vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

a) Mental Healthcare

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 Personcan avail Hospitalization at home under Home Healthcare for Medically Necessary Treatment of Illnesses, if prescribed by treating Medical Practitioner. We will pay Medical Expensesunder Section B-I-1 incurred for treatment of such Illness where opted.

This Cover can be availed through Cashless Facilityonly as procedure given under Claims Procedure - Section E.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

3. Domiciliary Hospitalization

We will pay the Medical Expenses incurred on Domiciliary Hospitalization of theInsured Person provided that:

i. It has been prescribed by the treating Medical Practitioner and
ii. the condition of the Insured Personis such that he/she could not be removed to a Hospital or
iii. the Medical Necessary Treatment is taken at Home on account of non-availability of room in Hospital

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

4. Pre-hospitalization cover

We will pay for the Pre-hospitalization Medical Expenses incurred during the 60 days immediately before Hospitalization of an Insured Person provided that Claim under Section B-I-1 or B-I-6 is admissible under the Policy.

Where Insured Person has opted for Home Healthcare treatment under Section B-I-2, Pre-hospitalization Medical Expenses are payable up to 60 days prior to start of the Medical treatment and when it falls within the Policy Period.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

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 Claim under Section B-I-1 or B-I- 6 is admissible under the Policy

Where Insured Person has opted for Home Healthcare treatment under Section B-I-2, Post Hospitalization Medical Expenses are payable up to 180 days post completion of the medical treatment.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

6. Day Care Procedures

We will pay for the Medical Expenses under Section B-I-1 on Hospitalisation of Insured Person in Hospital or Day Care CentreforDay Care Treatment.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

7. Road Ambulance

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. of from Hospital to Home (within same City) following Hospitalization

provided that Claim under B-I-1 and B-I-6 is admissible under the Policy.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

8. Organ Donor Expenses

We will pay Medical Expenses as listed under Section B-I-1 towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient, provided 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 rules.

ii. Hospitalization Claim under Section B-I-1 is admissible under the Policy

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

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

9. Alternative Treatments

We will pay Medical Expensesas listed under Section B-I-1 on Inpatient Hospitalization of Insured Personin Ayush Hospital for following Alternative Treatments prescribed by Medical Practitioner

- Ayurvedic
- Unani
- Siddha
- Homeopathy

provided that;

i. The procedure performed on the Insured Person cannot be carried out on Outpatient basis

ii. In the event of admissible Claim under this Cover, no Claim shall be admissible under B-I-1 for Allopathic treatment of same Illness or Injury

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment is applicable

II. Renewal Benefits

1. Preventive Health Check-Up

After the completion of four consecutive, continuous and Claim free Policy Years with Us, We will pay towards cost of Preventive Health Check-upto specified percentage (as mentioned on the Schedule of Coverage) of Sum Insured for those Insured Persons who were Insured under the previous 4 Policy years with Us.

Other terms and Conditions applicable to this Benefit

- Post each block of four consecutive and continuous claim free Policy Years the Insured Persons can avail this benefit during the fifth Policy Year. The benefit will not be carried forward if not utilized during this stipulated timeframe. .
- Eligibility to avail Health Check-up will be in accordance to lower of expiring Policy Sum Insured or Renewed Policy Sum Insured.
- This cover is applicable only to Insured Person covered under all four Policy Years and who continue to remain insured in the subsequent Policy Year/ Renewal.
- Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Cumulative Bonus

2. Cumulative Bonus

On each Renewal of the Policy with Us, We will apply 5% of Basic Sum Insured under expiring Policy as Cumulative Bonus in the Policy provided that;

i. There has been no claim under the Policy in expiring year under Section B-I

ii. Cumulative Bonuswill be reduced at the same rate as accrued in the event of admissible Claim under Section B-I of the Policy.

iii. Cumulative Bonuscan be accumulated upto 50% of Basic Sum Insured.

iv. Cumulative Bonusapplied will be applicable only to Insured Person covered under expiring Policy and who continue to remain insured on Renewal.

v. In case of multiyear policies, Cumulative Bonusthat has accrued for the second and third Policy Year will be credited on Renewal. Accrued Cumulative Bonus may be utilized in case of any Claim during Policy tenure

3. my: Health Active

A. 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 OurHDFC ERGO Mobile App and Your Policy number

OR

- burning total of 900 calories upto maximum of 300 calories in one exercise session per day, tracked Your wearable device linked to OurHDFC ERGO Mobile App and YourPolicy 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	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%

Steps to accumulate Healthy Weeks

Step 1 - The HDFC ERGO Mobile App must be downloaded on the mobile.

Step 2 - You can start accumulating Healthy Weeks by tracking physical activity trough the Wearable device linked

To Our HDFC ERGO Mobile App and 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 PolicyYearwill be applied on the Renewal Premium for expiring Policy Sum Insured and for Insured Person covered under expiring Policy

• **Multi Year Policy**:

- o Fitness discount earned on yearly basis will be accumulated till Policy End date.
- o 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 covered under expiring 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 expiring PolicySum Insured.
- Fitness discount @ Renewal will be applied only on Renewal of Policy with Us and only if accrued.

B. Health Incentive

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 Insuredand for Insured Person covered under expiring Policy
- **Multi Year Policy:**

o 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 expiring Policy
- For Policiescovering more than one Insure Person,testsshall 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 Usand 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.

C. Wellness services:

The services listed below are available to all Insured Person through Our Network Provider on Our HDFC ERGO Mobile App only. Availing of services under this Section will not impact the Sum Insured or the eligibility for Cumulative Bonus.

i. Health Coach:

An Insured Person will have access to Health Coaching services in aregiven 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.

These services will be available through Our HDFC ERGO Mobile App

Disclaimer applicable to HDFC ERGO Mobile App and 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.

III. Optional Covers

Preamble

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.

1. Preventive Health Check-Up - Booster

On opting this Cover, Insured Person will be entitled for Health Check-up after the completion of each Policy Year with Us irrespective of Claims made under the Policy in accordance with options given below.

i. We will reimburse the cost of Preventive Health Check-up to limits mentioned on the Schedule of Coverage.

Or

ii. Insured Person shall have the option to undergo Health Check-Up at our Network Service Provider in accordance to criteria given below.

Sum Insured	Tests
Upto 2 Lacs	Medical Examination Report, Complete Blood Count Urine R, Fasting Blood Sugar, Serum Creatinine, Lipid Profile, Electro Cardio Gram
3 Lac and above	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 Cover

- This benefit will not be carried forward if not utilized within the first 60 days post Policy Anniversary/ Renewal date.
- On opting this Cover, Renewal Benefit, Preventive Health Check-up under Section B-III-1 stands deleted.

2. Parent and Child care Cover - Basic

We will pay to the Insured Person subject to waiting period as mentioned in the Schedule of Coverage on the Policy Schedule under Covers as given below.

I. Parent Care

i. Medical Expenses under Section B-I for Maternity Expenseslimitedup to 2 deliveries or 1 delivery and 1 termination or 2 terminations during the lifetime of the Insured Person

ii. OPD Treatment in Pre-natal and Post-natal period provided Claim under Maternity Expenses is admissible under the Policy.

Note: If this optional cover is in force, then Specific Permanent Exclusions II.xiv) shall be superseded only to the extent of coverage provided under this benefit.

II. Child Care

We will pay/cover following expenses towards Child Care for New Born Baby under this cover if Claim for Maternity Expenses is admissible under the Policy.

i. We will pay Medical Expenses listed under Section B-I within Sum Insured for Parent Care towards treatment of a New Born Baby as per limit mentioned on Schedule of Coverage.

ii. New Born Baby Cover - We will cover New Born Baby from 91st day after the birth as per original terms of the Policy on receipt of completed proposal form and Premium received within 90 days of birth of Baby and subject to acceptance by Us.

If this Cover is opted, General exclusion xv) under General Exclusions, Section C-1-II, stands deleted.

Exclusions applicable to this Cover.

i. Pre-Hospitalization and post-Hospitalization expenses are not payable under this cover

ii. We will not pay any expenses related to ectopic pregnancy under this cover. Ectopic pregnancy will be covered as a part of expenses under Section B-I only.

iii. Treatment for impotency, treatment to effect infertility, surrogate or vicarious pregnancy, voluntary termination of pregnancy, procedures to assist birth control, contraceptive supplies.

3. Parent and Child care Cover – Booster

We will pay to the Insured Person subject to waiting period and limits as mentioned in the Schedule of Coverage on the Policy Schedule under Covers as given below.

Furthermore, If Parent and Child care Cover – Booster is opted, then the below shall stand deleted:

a. Parent and Child care Cover – Basic

b. General exclusion C.1.II. xiv), C.1.II.xv) and C.2.II. xi)

I. Parent Care

i. Maternity Expenses - Medical Expenses for a delivery (including caesarean section) on Hospitalization or the lawful medical termination of pregnancy during the Policy Period.

ii. OPD Treatment in Pre-natal and post-natal period up to the limit of this cover, provided Claim under i. Maternity Expenses is admissible under the Policy

iii. Infertility Treatment: Medical Expenses listed under Section B-I incurred for infertility treatment, assisted reproductive treatments undertaken on advice of a Medical Practitioner, up to 50% of Normal Delivery Sum Insured under this Cover. This cover is applicable for both Male and Female Insured Person

Note: If this optional cover is in force, then Specific Permanent Exclusions II.xiv) shall be superseded only to the extent of coverage provided under this benefit.

II. Child Care

We will pay following expenses towards Child Care for New Born Baby under this cover if Claim for Maternity Expenses is admissible under the Policy.

i) New Born baby cover:

We will pay Medical Expenses listed under Section B-I1 towards treatment of a New Born Baby within the limit of Sum Insured under Parent and Child Care cover as mentioned in Schedule of Coverage on the Policy Schedule

ii) Vaccination Charges:

We will pay expenses incurred on vaccination for New Born Baby as per National Immunization Schedule until New Born Baby completes 1 year of age subject to maximum of sub limit of Sum Insured under Parent and Child Care cover.

III. Waiting Period modification Option

On availing this option, Waiting Period listed under Section C.2.I (i), will stand modified as mentioned in the Schedule of Coverage on the Policy Schedule.

All other terms and conditions of the Parent & Child Care Cover - Booster shall remain unaltered.

Exclusions applicable to this Cover.

i. Pre-Hospitalization and post-Hospitalization expenses are not payable under this cover

ii. We will not pay any expenses related to ectopic pregnancy under this cover. Ectopic pregnancy will be covered as a part of expenses under Section B-I only.

iii. Treatment for impotency, treatment to effect infertility, surrogate or vicarious pregnancy, voluntary termination of pregnancy, procedures to assist birth control, contraceptive supplies.

4. Air Ambulance Cover

We will pay for Air Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid ambulance transportation as prescribed by a Medical Practitioner, from the site of first occurrence of the Illness/ Accident to the nearest Hospital, that ground transportation

cannot provide. Claim would be reimbursed up to the actual expenses subject to a maximum of Sum Insured as specified on the Schedule of Coverage in the Policy Schedule.

Furthermore, for availing the benefit under this cover, claim for inpatient Hospitalization needs to be admissible under Section B-I Hospitalization Cover

Exclusion:

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

5. Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule upon Medically Necessary Hospitalization of an Insured Person exceeding 10 consecutive and continuous days and for which Claim is admissible under Section B-I– Hospitalization Cover.

This benefit is not applicable if Medical treatment is taken under Section B-I2 – Home Healthcare and B-I-3 – Domiciliary Hospitalization.

6. 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 on subsequent Hospitalization of the Insured Person during Policy Year subject to

i. The 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/Extended Cumulative Bonus (if applicable) earned and Sum Insured Rebound will be available to all Insured Persons for all claims under Section B-I 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/Extended Cumulative Bonus (if opted) 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. The Sum Insured Rebound can be utilized for Claims under Section B-I only.

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	4	0	0	70,000	50,000	3,00,000	50,000

Illustration 2

Time	Claim no.	Sum Insured available	Cumulative Bonus	Admissible Claim amount	SI Rebound	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

7. Outpatient Dental Treatment

After three consecutive and continuous Policy Year with Us, We will pay 50% of Medical Expenses incurred by Insured Person towards Dental Treatment prescribed by Medical Practitionerup to the amount as mentioned in the Schedule of Coverage on the Policy Schedule. Claim under this Section can be availed only through our Network Provider. The Cover is applicable only to Insured Person covered under three consecutive and continuous Policy Years and who continue to remain insured in the subsequent Policy Year/Renewal

The Coverage is applicable only towards cost of X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same.

Claim under this Section will not affect Cumulative Bonus under Section B-II-2, condition ii.

If this optional cover is in force, then Specific Permanent Exclusions II.xiv shall be superseded only to the extent of coverage provided under this benefit.

Exclusions specific to Outpatient Dental Treatment

i. Cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury due to an accident or cancer

8. External Medical Aids

After the completion of every two consecutive and continuous Policy Year with Us, We will pay up to 50% of cost incurred towards following Medical Expenses subject to maximum of Sum Insured as mentioned in the Schedule of Coverage, on the Policy Schedule;

i. One pair of spectacles or one pair of contact lenses,

ii. A hearing aid

Other terms

- The Cover is applicable only to Insured Person covered under two consecutive and continuous Policy Years and who continue to remain insured in the subsequent Policy Year/Renewal
- Under a Family Floater Policy, Our liability shall be limited to either one pair of spectacles or contact lenses or hearing aid per family.
- Post completion of every two consecutive and continuous Policy Years the Insured Persons can avail this benefit during the third Policy Year. The benefit will not be carried forward if not utilized during this stipulated timeframe.
- Medical Expenses incurred under this Cover shall be prescribed by treating Medical Practitioner.
- Claim under this Section will not affect Cumulative Bonus under Section B-II-2, condition ii

9. Major Illness Hospitalization Expenses

We will pay for Medical Expenses incurred and admissible under Section B-I-1,up to additional Sum Insured equivalent to Basic Sum Insured,onMedically necessary Hospitalization of Insured Person for Major illnesseslisted below whose diagnosis first commence/occursafter the applicable waiting period from commencement of the first Policy with Us, subject to the following;

i. Waiting Period – The coverage is subject to Waiting Period as mentioned on Schedule of Coverage on the Policy Schedule

ii. Claim for each Major Illnessis payable only once during the lifetime of Policy with Us. However, Insured Person will continue to be covered under this Section for other Major Illnesses.

iii. Claim under this Cover is admissible only when total of Basic Sum Insuredis completely utilized.

iv. The additional Sum Insured under this Cover is exclusive and specific for the treatment of the first occurrence of the above Critical Illness undertaken in a Hospital/Nursing Home as an in-patient and will not be available for other illnesses/hospitalization.

Major Illness Covered	
1	Cancer of specified severity
2	Open Chest CABG
3	Myocardial Infarction((First Heart Attack of specific severity)
4	Kidney Failure requiring regular dialysis
5	Multiple Sclerosis with Persisting Symptoms
6	Major Organ/Bone Marrow Transplant
7	Stroke resulting in permanent symptoms
8	Surgery of Aorta
9	Primary (Idiopathic) Pulmonary Hypertension

10. Non-Medical Expenses cover

We will pay for Non-Medical Expenses upto the limit mentioned in Schedule of Coverage in the Policy Schedule on Medically necessary Hospitalization of Insured Person for claims admissible under Section B-I-1, 2 and 3.

In view of this Cover, Exclusion C.2.II. xii) of Section C, shall stand covered upto the extent mentioned above.

11. Waiting period Modification Option

On availing this option, Waiting Periods listed under Section C 1.I – i, ii and iii will stand modified as mentioned in Schedule of Coverage on the Policy Schedule for following Sections;

Section B-I – Hospitalization Cover

Section B-III4 – Air Ambulance

Section B-III5 – Recovery Benefit

Section B-III9 – Major Illness Hospitalization Expenses

Section B-III17 – Hospital Cash

Section B-III18 – Global Health Cover

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

12. Extended Cumulative Bonus

On availing this cover, Cumulative Bonus percentage mentioned under Section Section B-II-2 Cumulative Bonus will stand modified as mentioned in Schedule of Coverage on the Policy Schedule subject to;

i. Once the Extended Cumulative Bonus benefit is availed by the Insured Person, it cannot be opted out at subsequent Renewal.

ii. All other terms and Conditions of Renewal Benefits Section B-II, ii shall remain unaltered.

13. Room Rent Modification Option

On availing this option, limits specified under Section B-I1 i

and B-I-1 ii will stand modified as below.

i. Room Rent, boarding and Nursing – limit of 1% of the Basic Sum Insured subject to maximum of Rs. 5,000 per day

ii. Intensive care unit - limit of 2% of the Basic Sum Insured subject to maximum of Rs. 10,000 per day

Proportionate deduction:

In case Room Rent during Hospitalization of Insured Person exceeds the aforesaid limits, 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.

14. Co-Payment

On availing this option, Co-Payment as mentioned on the Schedule of Coverage in the Policy Schedule will be applied on each and every admissible claim after Deductible/Excess wherever applicable under the Policy. Once the Co-Payment option is availed by the Insured Person, it cannot be opted out of at subsequent Renewal.

15. Major Illness – Benefit

If the eldest Insured Person covered under the Policy suffers from Major Illnessas listed below, whose diagnosis first commence/occurs after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured as mentioned on the Schedule of Coverage.

The Coverage under this benefit shall cease to exist upon occurrence of any one Major Illness covered for which Claim is admitted by the Company.

Major Illness Covered	
1	Cancer of specified severity
2	Open Chest CABG
3	Myocardial Infarction (First Heart Attack of specific severity)
4	Kidney Failure requiring regular dialysis
5	Major Organ/Bone Marrow Transplant
6	Multiple Sclerosis with Persisting Symptoms
7	Permanent Paralysis of Limbs
8	Stroke resulting in Permanent Symptoms
9	Surgery of Aorta
10	Primary (Idiopathic) Pulmonary Hypertension
11	Open Heart Replacement or Repair of Heart Valves

Survival Period

Claim under this Cover is payable only if Insured Person survives 30 days from the diagnosis, fulfillment of the definition of the Major illness covered and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem)

Waiting Period

• A waiting period of 90 days shall apply for all claims under this cover

16. E-Opinion

We will pay expenses incurred towards second Medical Opinion availed from Medical Practitioner in respect of Major Illness covered and listed below under the Policy through our Network Provider.

The Coverage under this benefit shall cease to exist upon availing Second Opinion for any one Major Illness as listed below.

Major Illness Covered	
1	Cancer of specified severity
2	Open Chest CABG
3	Myocardial Infarction (First Heart Attack of specific severity)
4	Kidney Failure requiring regular dialysis
5	Major Organ/Bone Marrow Transplant
6	Multiple Sclerosis with Persisting Symptoms
7	Permanent Paralysis of Limbs
8	Stroke resulting in Permanent Symptoms
9	Surgery of Aorta
10	Primary (Idiopathic) Pulmonary Hypertension
11	Open Heart Replacement or Repair of Heart Valves

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

17. Hospital Cash

We will pay per day Sum Insured up to maximum Number of days and in manner as specified in Schedule of Coverage on the Policy Schedule for each continuous and completed period of 24 hours of Medically Necessary Hospitalization of an eldest Insured Person in the Policy and for which Claim is admissible under Section B-I– Hospitalization Cover.

18. Global Health Cover

On availing this Cover, We will pay the Medical Expenses incurred outside India under below given Sections and Covers wherever opted and as mentioned on the Schedule of Coverage in the Policy Schedule.

Section B-I: Hospitalization Cover	
B1	Medical Expenses
B4	Pre-Hospitalization cover
B5	Post-Hospitalization cover
B6	Day Care Procedures
B7	Road Ambulance
B8	Organ Donor Expenses
B9	Alternative Treatments

Section B-III : Optional Covers	
B-III-1	Preventive Health Check-Up - Booster
B-III-2	Parent and Child care Cover - Basic
B-III-3	Parent and Child care Cover – Booster
B-III-4	Air Ambulance Cover
B-III-5	Recovery Benefit
B-III-6	Sum Insured Rebound
B-III-7	Outpatient Dental Treatment
B-III-8	External Medical Aids
B-III-9	Major Illness Hospitalization Expenses
B-III-10	Non-Medical Expenses cover
B-III-15	Major Illness – Benefit
B-III-16	E-Opinion
B-III-17	Hospital Cash

Global Cover is applicable subject to following terms and conditions

i. Global coverage for expenses towards all the listed covers is applicable and effective only if mentioned on the Schedule of Coverage in the Policy Schedule.

ii. A Deductible of USD 100 will apply for expenses under all the respective covers separately for each and every claim.

iii. Claims on Reimbursement basis will be payable in INR only.

iv. All other terms and conditions of the respective Section and Covers under the policy shall remain unaltered

19. Surrogacy & Oocyte Donor Complications

We will indemnify the Insured Person for the below mentioned expenses subject to compliance of the Surrogacy Act 2012, The Assisted Reproductive Technology (Regulation) Act, 2021 & rules framed there (and as amended from time to time and another relevant law), the waiting period and limits as mentioned below.

i. Surrogacy complications: We will indemnify **Medical Expenses** listed under Section B-I-1 incurred only for any type of complications (including post-partum delivery complications) faced by the **Surrogate Mother** arising out of pregnancy.

Conditions applicable for Surrogacy complications

a. Claim under this sub-benefit shall be payable only if the Surrogacy is for the Insured Person under this Policy

b. The claim admissible under this sub-benefit must be Medically Necessary and the same should be certified by the treating Medical Practitioner of such Insured Person.

c. We shall cover **Surrogacy** complications and post-partum delivery complications for upto a period of 36 months starting from the date the first complication arises under this sub-benefit, subject to continuous renewal of the policy for the stated period.

d. We will indemnify **Medical Expenses** listed under Section B-I-1 towards Surrogacy complications. Such expenses shall be covered upto Sum Insured as specified in the Policy Schedule.

e. Claims paid under this sub-benefit shall be in accordance and in compliance with Surrogacy Act, 2012, ART Act, 2021, ART (Regulation) Rules,2022 & Surrogacy (Regulation) Rules, 2022 and its amendments from time to time.

f. No woman, other than an ever married woman having a child of her own and between the age of 25 to 35 years on the day of implantation shall be a surrogate mother

g. The intending couple shall be married and between the age of 23 to 50 years in case of female and between 26 to 55 years in case of male

h.The Surrogacy Act 2012 & The Assisted Reproductive Technology (Regulation) Act, 2021 shall always supersede the policy wordings in case of any amendments in the said Acts.

i.Any claim triggered under this benefit shall reduce the Sum Insured of this Policy for that Policy Year.

ii. Oocyte donor complications: We will indemnify **Medical Expenses** listed under Section B-I-1 incurred only for any type of complications faced by the **Oocyte** donor arising due to **Oocyte** retrieval.

Conditions applicable for Oocyte donor complications

a. We shall cover any type of Oocyte donation complications arising for upto 12 months from the date the first complication arises under this sub-benefit, subject to continuous renewal of the policy for the stated period.

b. Claim under this sub-benefit shall be payable only if the **Oocyte** donation is related to and for a person Insured under this Policy

c. The claim admissible under this sub-benefit must be Medically Necessary and the same should be certified by the treating Medical Practitioner of such Insured Person.

d. Claims paid under this sub-benefit shall be in accordance and in compliance with Surrogacy Act,

2012, ART Act, 2021, ART (Regulation) Rules,2022 & Surrogacy (Regulation) Rules, 2022 and its amendments from time to time.

e. We will indemnify Medical Expenses listed under Section B-I-1 towards Oocyte donor complications. Such expenses shall be covered upto Sum Insured as specified in the Policy Schedule.

f. No woman, other than an ever married woman having a child of her own and between the age of 25 to 35 years on the day of implantation, shall help in surrogacy by donating her egg or oocyte or otherwise.

g. The intending couple shall be married and between the age of 23 to 50 years in case of female and between 26 to 55 years in case of male

h. The Surrogacy Act 2012 & The Assisted Reproductive Technology (Regulation) Act, 2021 shall always supersede the policy wordings in case of any amendments in the said Act.

i. Any claim triggered under this benefit shall reduce the Sum Insured of this Policy for that Policy Year.

I. Waiting Period

The Insured Person in respect of whom a claim for 'Surrogacy & Oocyte Donor Complications' is made must have been covered as an Insured Person for a period of 48 months of continuous coverage since the inception of the First Policy, with 'Surrogacy & Oocyte Donor Complications' as a benefit, with Us.

Furthermore, in case of Migration and Portability afresh waiting periods shall apply for Surrogacy complications and Oocyte donor complications cover.

II. Exclusions applicable to this Cover

i. The intending couple have not had any surviving child biologically or through adoption or through surrogacy earlier

ii. No woman shall act as a surrogate mother more than once in her lifetime.

iii. No woman shall act as a surrogate mother by providing her own gametes

iv. No surrogacy or surrogacy procedures shall be conducted, undertaken, performed or availed of, except for the purpose when the intending couple has a medical indication necessitating gestational surrogacy.

SECTION C: WAITING PERIODS AND EXCLUSIONS

1. Standard Exclusions and Waiting Period

I. 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 48 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 48 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.

a. Illnesses

Diseases of gall bladder including cholecystitis	Non infective Arthritis
Pancreatitis	calculus diseases of Urogenital system e.g.Kidneystone,Urinary Bladder Stone
All forms of Cirrhosis	Ulcer and erosion of stomach and duodenum
Perineal Abscesses	Gastro Esophageal Reflux Disorder (GERD)
Cataract	Perianal Abscesses

Pilonidal sinus	Fissure/fistula in anus, Haemorrhoids includingGout and rheumatism
Benign tumors, cysts, nodules, polyps including breast lumps	
Polycystic ovarian diseases	Osteoarthritis and osteoporosis
Sinusitis, Rhinitis	Fibroids (fibromyoma)
Skin tumors	Tonsillitis
Benign Hyperplasia of Prostate	

b. Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy
Dilatation and curettage (D&C)	Nasal concha resection
Myomectomy for fibroids	Surgery of Genito urinary system
Surgery on prostate	Cholecystectomy
Hernia	Hydrocele/Rectocele
Surgery for prolapsed inter vertebral disc	Joint replacement surgeries
Surgery for varicose veins and varicose ulcers	Surgery for Nasal septum deviation
Surgery for Perianal Abscesses	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.

iv) A waiting period of 48 months (unless specified otherwise in your plan opted) shall apply for all Claims under Parent and Child Care Cover - Basic/Parent and Child Cover - Booster

II. **Standard Permanent Exclusions**

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

i. Investigation & Evaluation: Code – Excl04

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

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

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

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

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 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: Code11 -** 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. Refractive Error: Code - Excl15 – Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

xiii. Unproven Treatments: Code – Excl16 – 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.

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.

2. Specific Exclusions and Waiting Period

I. Specific Waiting Periods

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

i)A waiting period of 48 months (unless specified otherwise in your Policy Schedule) shall apply for all Claims under Parent and Child Care Cover – Basic/Parent and Child Cover – Booster (Section B-III, 2 and 3)

II. Specific 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. 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 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 treatment 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 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 expenses is attached and also available at www.hdfcergo.com.

xiii. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner

who is a member of an Insured Person's family, or stays with him,

xiv. Treatment taken on Outpatient basis

xv. The provision or fitting of hearing aids, spectacles or contact lenses.

xvi. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement method. Optometric therapy.

xvii. 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.

xviii. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs crutches and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses is attached and also available on www.hdfcergo.com.

xix. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

xx. Any type of Non-Allopathic treatment except mentioned under Section B-I-9 Alternative Treatments

SECTION D: GENERAL CONDITIONS

Standard General Conditions

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 fifteen 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

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 thisPolicy.

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 eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

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:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the GracePeriod of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

9. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 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

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. Cancellation

i. The Policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policies where instalment option is not availed and no claim has been made under the Policy, We will refund premium in accordance with the table below:

Month	Policy Tenure 1 Year	Policy Tenure 2 Year	Policy Tenure 3 Year
Up to 1 Month	85.0%	92.5%	95.0%
Up to 3 Month	70.0%	85.0%	90.0%
Up to 6 Month	45.0%	70.0%	80.0%
Up to 12 Month	0.0%	45.0%	60.0%
Up to 15 Month	NA	30.0%	50.0%
Up to 18 Month	NA	20.0%	45.0%
Up to 24 Month	NA	0.0%	30.0%
Up to 27 Month	NA	NA	20.0%
Up to 30 Month	NA	NA	12.5%
Up to 36 Month	NA	NA	0.0%

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

- When yearly payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable
- For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
- In case of admissible claim under the Policy, future instalments for the current policy year will be adjusted

in the claim amount and no refund of any premium will be applicable during policy year

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

12. 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

ii. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

iii. 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.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the Grace Period, the Policy will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. 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

13. Possibility of Revision of terms of the Policy including the Premium Rates

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

14. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

15. Claim Settlement (Provision for Penal Interest)

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 Ourcost, 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

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
- Toll free: 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://bimabharosa.irdai.gov.in

Specific General Conditions

1. Non-Disclosure or Misrepresentation

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

a) cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us at Our sole discretion, upon 15 days' 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 1 i above.

2. Geography

This Policy only covers Medical Treatment taken within India, except under the policies with Global Health Cover as may be specified in the on the Schedule of Coverage in the policy Schedule.

3. Loadings

i. We may apply Medical Underwriting 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. Medical Underwriting 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 B-III-3** Health Incentives

iv. We will inform You about the applicable Medical underwriting 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.

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 Periodwill not be covered and will be treated as Pre-existing diseases.

ii. Policies for which Premium is received aftertheGrace Period shall be considered as a fresh policy.

iii. For Policies on instalment basis, Grace Period is available as given below.

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:

1. 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 (if this does not impact the premium)*

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

2. Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth

ii. Change in Height, weight

iii. Addition of Insured Person (New Born Baby or newly wedded spouse)

iv. Deletion of Insured Person on death or Marital separation

v. Any other financial endorsement

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

6. Premium Tier

For the purpose of policy issuance, the premium will be computed basis the tier chosen by the Policy holder in the proposal form and as mentioned in the Policy Schedule. Classification of cities would be as under:

- Tier 1 : Delhi, NCR, Mumbai, Thane, Mumbai Suburban and Navi Mumbai, Surat, Ahmedabad & Vadodara
- Tier 2 : Rest of India- All other cities

Conditions:

I. On payment of Tier 1 premiums, an Insured Person can avail treatment all over India without any co-payment.

II. On payment of Tier 2 premium, an Insured Person can avail treatment at Tier2 cities without any Co-Payment. However if an Insured Person avails a treatment in Tier 1 cities , 20% Co-Payment shall be applicable on admissible claim amount.

III. Co-Payment under ii above will not be applied If an Insured Person opts for Hospitalization with Room Rent up to Rs 2,500 per day or on Hospitalization for Medically Necessary treatment following an Accident

7. Premium Rate

- The premium under individual coverage will be charged on the completed age of the individual insured member.
- In case of Family Floater policies Floater discount of 50% will be applied on all the members except the oldest member.
- The premium for the policy will remain the same for the Policy Period mentioned in the policy schedule.
- Please note that your premium at renewal may change due to a change in your age or changes in the applicable tax rate.
- Premium rates are subject to change with prior approval from IRDA.
- The Sum Insured of the dependent insured members should be equal to or less than the Sum Insured of the Primary Insured member. In case where two or more children are covered, the Sum Insured for all the children must be same. Sum insured of all Dependent Parents and Dependent Parent in law must be same.

Please Note. Premium rates and policy terms and conditions are for standard healthy individuals. These may change post underwriting of proposal based on medical tests (where applicable) and information provided on the proposal form.

SECTION E: OTHER TERMS & CONDITIONS

Contact Us

	Within India	**Outside India**
Claim Intimation	Toll Free :022 6234 6234 / 0120 6234 6234 Email: healthclaims@hdfcergo.com	Toll Free No: 800 08250825 Global Toll Free 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, Andheri Kurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

Claim Procedure

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				
Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 24 hours of the Emergency Hospitalization At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier	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, Wewill 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 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		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. vi. On receipt of the complete documents 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 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

List of Documents for Reimbursement Claims:

i. Duly signed, stamped and completed Claim Form

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 Network Provider's Registration Certificate / Hospital registration no in case of Hospitalization

v. Original Discharge Card / Day Care Summary / Transfer Summary

vi. Original final Hospital Bill with all original deposit and final payment receipt

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

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. Copy of Death Summary and copy of Death Certificate (in death claims only)

xiii. Pre and Post-Operative Imaging reports

xiv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress

xv. Original invoice for Vaccination and payment receipt

xvi. KYC documents

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

List of Ombudsman

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 | Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 | Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 | Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh
GUWAHATI 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.
HYDERABAD 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 | Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 | Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 | Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II,Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad 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 Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I - List of Non-Medical Expenses

S. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)

S. No.	Item
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

S. No.	Item
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

S. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP

S. No.	Item
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

S. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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