HDFC ERGO General Insurance Company Limited

Policy Wording
Easy Health

Preamble

HDFC ERGO General Insurance Company Limited will cover all Insured Persons under this Policy upto the Sum Insured. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

SECTION A. DEFINITIONS & OTHER IMPORTANT TERMS YOU SHOULD KNOW

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

1. Standard Definitions

Def. 1 **Accident** 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 it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Def. 3 **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

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

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

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

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

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

Def. 5 **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

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

Def. 7 **Congenital Anomaly** refers to 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 claim amount. A co-payment does not reduce the Sum Insured.

Def. 9 **Cumulative Bonus** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 10 **Critical Illness** means Cancer of specified severity, Open Chest CABG, First Heart Attack of specified severity, Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs, Stroke resulting in Permanent Symptoms as defined below only:

i) **Cancer of specified severity:**

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma

- 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
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder

ii) Open Chest CABG:

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The Diagnosis must be supported by coronary angiography and realisation of the surgery has to be confirmed by a specialist Medical Practitioner

The following are excluded:

- Angioplasty and / or Any other intra-arterial procedures
- Any Key-hole surgery or laser surgery

iii) First Heart Attack of Specified Severity:

The first occurrence of 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 this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
- New characteristic electrocardiogram changes.
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.
- Other acute Coronary Syndromes.
- Any type of angina pectoris

iv) Kidney Failure requiring Regular Dialysis:

End stage renal disease presented as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out.

The diagnosis has to be confirmed by a specialist Medical Practitioner

v) Major Organ/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

- One of the following human organs - heart, lung, liver, pancreas, kidney, that resulted

from irreversible end-stage failure of the relevant organ or;

- Human bone marrow using hematopoietic stem cells.

The undergoing of a transplant must be confirmed by specialist medical practitioner.

The following are excluded:

- Other Stem-cell transplants
- Where only islets of Langerhans are transplanted

vi) <u>Multiple Sclerosis with Persisting Symptoms</u>:

The definite occurrence of Multiple Sclerosis**.**The diagnosis must be supported by all of the following:

- Investigation including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple Sclerosis.
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least 1 month apart.

Excluded is:

- Neurological damage due to SLE is excluded.

vii) <u>Permanent Paralysis of Limbs</u>:

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 (Physician / Neurologist) must be of the opinion that paralysis will be permanent with no hope of recovery and must be present for more than 3 months. .

viii)<u>Stroke resulting in Permanent Symptoms</u>:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source.

The 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 atleast 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular diseases affecting only the eye or optic nerve or vestibular functions

Def. 11 **Day Care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- 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. 12 **Day Care Procedures** means those medical treatment, and/or surgical procedure

i. which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement,

ii. which would have otherwise required a Hospitalisation of more than 24 hours.

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

Def. 13 **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. 14 **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, filings (where appropriate), crowns, extractions and surgery.

Def. 15 **Domiciliary Hospitalisation** means medical treatment for an illness/disease/injury which in the normal course would require a care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

Def. 16 **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. 17 **Emergency Care** means management for a severe 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. 18 **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium

payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def. 19 **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock,
- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- 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. 20 **Hospitalisation or Hospitalised** means admission in a Hospital for a minimum 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. 21 **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

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 disease, illness, or injury that has one or more o f the following characteristics:

— it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

— it needs ongoing or long-term control or relief of symptoms

— it requires your rehabilitation or for you to be specially trained to cope with it

— it continues indefinitely

— it recurs or is likely to recur

Def. 22 **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. 23 **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. 24 **Maternity expenses** means

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections during hospitalization);

ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

Def. 25 **Medical Advice** means any consultation or advise from a Medical Practitioner including the issuance of any prescription or follow up prescription.

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

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

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

Def. 28 **Medical Practitioner** means a person who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Def. 29 **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 30 **Network Provider** means Hospital enlisted by an insurer or a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility.

Def. 31 **New Born Baby** means baby born during the Policy Period and is aged up to 90 days.

Def. 32 **Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium.

Def. 33 **Non Network Provider** means any Hospital, day care centre or other provider that is not part of the Network

Def. 34 **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any

of the recognized modes of communication.

Def. 35 **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. 36 **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

Def. 37 **Pre-Existing Disease** means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def. 38 **Pre-Hospitalisation Medical Expenses** means the medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 39 **Post-Hospitalisation Medical Expenses** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

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

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

Def. 40 **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. 41 **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 42 **Room Rent** means the amount charged by a hospital towards room and boarding expenses and shall include associated medical expenses.

Def. 43 **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. 44 **Surgery** or **Surgical Procedure** means manual and/or operative procedure(s) required for

treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 45 **Unproven/Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 46 **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. 47 **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the coverage for bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2. 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 per last birthday at the inception of the relevant policy year.

Def. 3 **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 4 **Base / Basic Sum Insured means** the limit opted at the time of inception or modified at the time of renewal whichever is later. It forms a part of the Sum insured for a given Policy Year. It is on per Policy Year basis. In case of Individual Policies, Base Sum Insured shall be on per Insured Person basis. In case of Family Floater policies, a common Base Sum Insured shall be available on a floating basis amongst all the Insured Persons.

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

Def. 6 **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

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

Def. 8 **Dependents** means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;

ii) Your children / Grandchildren Aged between 91 days and 25 years if they are unmarried and

financially dependent with no independent source of income. Children Aged between 1 to 90 Days can be covered if Newborn Baby Benefit is added by payment of additional premium subject to policy terms and conditions.

iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Easy Health Policy,

iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Easy Health Policy

v) Your Grandparents provided that the grandparent were below 65 years at his initial participation in the Easy Health Policy,

All Dependent parents, Parent in laws, Grand Parents must be financially dependent on You.

Def. 9 **Dependent Child** means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income. Children Aged between 1 to 90 Days can be covered if Newborn Baby Benefit is added by payment of additional premium subject to policy terms and conditions.

Def. 10 **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Year.

Def. 11 **Insured Person** means You and the persons named in the Schedule.

Def. 12 **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. 13 **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure 1 and the Schedule (as the same may be amended from time to time).

Def. 14 **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 15 **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 16 **Shared accommodation means** a Hospital room with two or more patient beds.

Def. 17 **Single occupancy** or **any higher accommodation type** means a Hospital room with only one patient bed.

Def. 18 **Sum Insured** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Year.

Def. 19 **TPA** means the third party administrator that We appoint from time to time as specified in the

Schedule.

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

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

SECTION B. BENEFITS

We will cover the Medical Expenses for:	**We will not cover treatment, costs or expenses for*:** *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section C-1,2,3 In addition to the waiting periods (Section C-1) and general exclusions (Section C-2&3), We will also not cover expenses
1) Inpatient Benefits: This section of benefits is applicable when • An insured suffers an Accident or Illness, which is covered under this Policy • Hospitalisation is necessary & is done for treatment OR • Day care treatment is necessary and is done OR • Domiciliary treatment is necessary and is done	
a) In-Patient Treatment This includes • Hospital room rent or boarding; • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	If as per any or all of the Medical references herein below containing guidelines and protocols for Evidence Based Medicines, the Hospitalisation for treatment under claim is not necessary or the stay at the hospital is found unduly long: • Medical text books, • Standard treatment guidelines as stated in clinical establishment act of Government of India, • World Health Organisation (WHO) protocols, • Published guidelines by healthcare providers, • Guidelines set by medical societies like cardiological society of India, neurological society of India etc.
b) Pre-Hospitalization Medical Expenses for consultations, investigations and medicines incurred upto 60 days before the date of admission to the Hospital (Inpatient or Day Care or Domiciliary treatment) **c)** Post-Hospitalization Medical Expenses for consultations, investigations and medicines incurred upto 90 days after discharge from Hospitalisation (Inpatient or Day Care or Domiciliary treatment).	**1.** Claims which have NOT been admitted under 1a), 1d) and 1e) **2.** Expenses not related to the admission and not incidental to the treatment for which the admission has taken place

d) Day Care Procedures Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours. Treatment normally taken on out-patient basis is not included in the scope of this definition.	**1.** Treatment that can be and is usually taken on an Out-Patient basis is not covered **2.** Treatment a NOT taken at a Hospital
e) Domiciliary Treatment 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: **1.** The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or, **2.** The Patient takes treatment at home on account of non availability of room in a Hospital. Pre and Post Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation and 90 days after hospitalization respectively will be covered in case of domiciliary treatment.	**1.** Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days only if treatment period is greater than 3 days)
f) Organ Donor: Medical and surgical expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an insured person while donating an organ is NOT covered.	**1.** Claims which have NOT been admitted under 1a) for insured member. **2.** Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). **3.** The organ donor's Pre and Post-Hospitalisation expenses.
g) Ambulance: Expenses incurred on a transportation of Insured Person to a Hospital for treatment in case of an emergency, subject to Rs. 2000 per Hospitalisation.	**1.** Claims which have NOT been admitted under 1a) and 1d) **2.** Healthcare or ambulance service provider not registered with road traffic authority.
h) Ayush Treatment Coverage upto Sum Insured only for Inpatient care expenses incurred on treatment taken under the below systems of medicine in an	**1.** Claims which have not been admitted under 1a) **2.** Hospitalisation for evaluation, Investigation only

AYUSH Hospital **a.** Ayurveda, **b.** Unani, **c.** Sidha, **d.** Homeopathy, **e.** Yoga & Naturopathy	**3.** Treatment availed outside India **4.** Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre.
i) Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as mentioned in schedule of Benefits if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.	**1.** Daily Cash Benefit for time spent by the Insured Person in an intensive care unit **2.** Claims which have NOT been admitted under 1a).
2) **Additional Benefits:** The following benefits are available to all Insured Persons during the Policy Period. Any claims made under these benefits will be subject to In-patient Sum Insured and will impact eligibility for Health Checkup These benefits are applicable based on the plan variant selected, as mentioned in the schedule of benefits.	
a) Daily Cash for Accompanying an Insured Child If the Insured Person Hospitalised is a child Aged 12 years or less, daily cash amount will be payable as mentioned in schedule of Benefits for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours.	**1.** Daily Cash Benefit for days of admission and discharge Claims which have NOT been admitted under 1a).
b) Newborn baby Medical Expenses for any medically necessary treatment described at 1)a) while the Insured Person (the Newborn baby) is Hospitalised during the Policy Period as an inpatient provided a proposal form is submitted for the insurance of the newborn baby within 90 days after the birth, and We have accepted the same and received the premium sought. Under this benefit, Coverage for newborn baby will incept from the date, the premium has been received. The coverage is subject to the policy exclusions, terms and conditions. This Benefit is applicable if Maternity benefit is opted and We have accepted a maternity claim under this Policy.	**1.** Claims which have NOT been admitted under 3a) i.e. Maternity Expenses **2.** Claims other than those available in Section B-1, Section C-1,2,3

c) Recovery Benefit Lumpsum amount will be payable as mentioned in schedule of Benefits if the Insured Person is Hospitalised as an inpatient beyond 10 consecutive and continuous days This benefit is payable only once per Illness/Accident per Policy Year.	**1.** Claims which have NOT been admitted under 1a).
d) Emergency Air Ambulance Cover We will pay for ambulance transportation in an airplane or helicopter subject to maximum limit prescribed in d(i), for emergency life threatening health conditions which require immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide subject to: • Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency; • The Medical Evacuation been prescribed by a Medical Practitioner and is Medically Necessary; • The insured person is in India and the treatment is required in India only and not overseas in any condition whatsoever; and • The air ambulance provider being registered in India. **d)(i)** The amount payable in case of Air ambulance facility shall be either the actual expenses or Rs. 2.5 Lacs per hospitalization, hichever is lower; upto basic sum insured limit for a year	**1.** Claims which have NOT been admitted under Inpatient Treatment or Day Care Procedures. **2.** Expenses incurred in return transportation to the insured's home by air ambulance is excluded.
3) Additional Benefit not related to Sum Insured: The following benefit is available to all Insured Persons during the Policy Period. Any claims made under these benefits will not be subject to In-patient Sum Insured and will not impact eligibility for a Cumulative Bonus and Health Checkup. These benefits are applicable based on the plan variant selected, as mentioned in the schedule of benefits.	
a) Maternity Expenses **i.** Medical Expenses for a delivery (including caesarean section) as mentioned in schedule of Benefits while Hospitalised or the lawful medical termination of pregnancy during the	**1)** Pre- and post-hospitalisation expenses under 1-b) and 1-c) **2)** Ectopic pregnancy under this benefit (although it shall be covered under 1a) **3)** Claim for Dependents other than

Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person **ii.** Medical Expenses for pre-natal and post-natal expenses per delivery or termination upto the amount stated in the Schedule of Benefits, **iii.** Medical Expenses incurred for the medically necessary treatment of the new born baby upto the amount stated in the Schedule of Benefits unless the new born baby is covered under 2b), and **iv.** The Insured Person must have been an Insured Person under Our Policy for the period of time specified in the Schedule of Benefits.	Insured Person's spouse under this Policy.
4) Critical Illness (Optional benefit) Any claims made under this benefit will not be subject to In-patient Sum Insured and will not impact eligibility for a Cumulative Bonus and Health Checkup. This benefit is optional and effective only if mentioned in the Schedule.	
a) Critical Illness (Optional benefit) We will pay the Critical Illness Sum Insured as a lump sum in addition to Our payment under 1)a), provided that: **i.** The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and **ii.** The Insured Person survives for at least 30 days following such diagnosis. **iii.** "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke. Note: Critical Illness (Optional benefit) is always provided on an individual Sum Insured basis irrespective of whether policy is issued on an individual or floater sum inured basis.	**1.** The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under an Easy Health Policy. **2.** The Insured Person has already made a claim for the same Critical Illness. **3.** A claim for this benefit has already been made 3 times under this Policy or any other Easy Health policy issued by Us.

5) Renewal Benefits:

5.1. Cumulative Bonus

On Renewal of this Policy with the Company without a break, a sum equal to 10% of the Base Sum Insured of the expiring Policy shall be provided as multiplier benefit irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions:

a. The maximum multiplier bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

b. In Family Floater policy, the Cumulative Bonus shall be available on Family Floater basis at policy level

c. In Family Floater policy, the accrued Cumulative Bonus is available to all Insured Persons under the Policy.

d. The applicable Cumulative Bonus shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy

e. If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the Cumulative Bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the Cumulative Bonus to be carried forward for credit in the Policy would be the lowest accrued Cumulative Bonus amongst all the Insured Persons from the expiring Policy.

f. Portability/migration benefit will be offered to the extent of sum of previous sum insured and accrued Cumulative Bonus, portability/migration benefit shall not apply to any other additional increased Sum Insured.

g. In policies with a 2year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.

5.2. Stay Active

We will offer a discount at each renewal if the insured member achieves the average step count target on the mobile application provided by Us in the specified time interval (calculated from the policy risk start date) as per the grid below. In an individual policy, the average step count would be calculated per adult member and in a floater policy it would be an average of all adult members covered. Dependent children covered either in individual or floater plan will not be considered for calculation of average steps.

This discount will be accrued at defined time intervals as given in table below. The discount will be cumulated and offered as discount on the renewal premium.

In individual policies the discount percentage (%) would be applied on premium applicable per insured member (Dependent Children are not eligible for this stay active discount in an individual policy) and in a floater policy it would be applied on premium applicable on policy.

The discount grid would be as per the table below:

1 Year Policy

	Time Interval (calculated from policy risk start date)				
Average Step Target	Risk start date or date of download of mobile application -90 days	91-180 days	181-270 days	271-300 days	Maximum Discount at the end of the year
5000 or below	0%	0%	0%	0%	0%
5001 to 8000	0.5%	0.5%	0.5%	0.5%	2%
8001 to 10000	1.25%	1.25%	1.25%	1.25%	5%
Above 10000	2%	2%	2%	2%	8%

2 Year Policy

	Time Interval ((calculated from policy risk start date)								
Average Step target	Risk start date or date of download of mobile application -90 days	91-180 days	181-270 days	271-360 days	361-450 days	451-540 days	541-630 days	631-660 days	Maximum Discount at the end of 2 years
5000 or below	0%	0%	0%	0%	0%	0%	0%	0%	0%
5001 to 8000	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	2%
8001 to 10000	0.625%	0.625%	0.625%	0.625%	0.625%	0.625%	0.625%	0.625%	5%
Above 10000	1%	1%	1%	1%	1%	1%	1%	1%	8%

The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit. The average step count completed by an Insured member would be tracked on this mobile application.

We reserve the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation.

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5.3. Preventive Health Check-up

a) If You have maintained an Easy Health Policy with Us for the period of time mentioned in the Schedule of Benefits without any break, then at the end of each block of continuous years (as mentioned in the Schedule of benefits) We will pay upto the percentage (mentioned in the Schedule of Benefits) of the Sum Insured for this Policy Year or the subsequent Policy Years (whichever is lower) towards the cost of a preventive health check-up for those Insured Persons who were insured for the number of previous Policy Years mentioned in the Schedule.

Note: If member has changed the plan in subsequent year and in the new plan the waiting period is less than previous plan then waiting period mentioned in the current plan would be applicable.

Plan	Standard	Exclusive
Easy Health Individual	Upto 1% of Base Sum Insured per Insured Person upto Rs.5000, only once at the end of a block of every continuous four claim free years.	Upto 1% of Base Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous three policy years
Easy Health Family	Upto 1% of Base Sum Insured per Policy upto Rs.5000, only once at the end of a block of every continuous four claim free years	Upto 1% of Base Sum Insured per Policy subject to a Maximum of Rs. 5,000 per Policy, only once at the end of a block of every continuous three policy years

b) In case of family floater in Standard Variant, if any of the members have made a claim under this Policy, the health check-up benefit will not be offered to the whole family.

c) We will consider complete policy years for the eligibility of this benefit.

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.

Illustration for Preventive Health Check-up in case Standard plan was opted on 13th April 2025 and renewed for a 1 year tenure every year.

Policy Year	Claim in the policy year	Policy Year in which Insured Person(s) is eligible and can avail Preventive Health Check-

		up
13th April 2025 to 12th April 2026	No	No
13th April 2026 to 12th April 2027	No	No
13th April 2027 to 12th April 2028	No	No
13th April 2028 to 12th April 2029	No	No
13th April 2029 to 12th April 2030	No	Yes
13th April 2030 to 12th April 2031	No	No
13th April 2031 to 12th April 2032	No	No
13th April 2032 to 12th April 2033	No	No
13th April 2033 to 12th April 2034	No	Yes

Illustration for Preventive Health Check-up in case Exclusive plan was opted on 13th April 2025 and renewed for a 1 year tenure every year.

Policy Year	Claim in the policy year	Policy Year in which Insured Person(s) is eligible and can avail Preventive Health Check-up
13th April 2025 to 12th April 2026	No	No
13th April 2026 to 12th April 2027	No	No
13th April 2027 to 12th April 2028	No	No
13th April 2028 to 12th April 2029	No	Yes
13th April 2029 to 12th April 2030	No	No
13th April 2030 to 12th April 2031	No	No
13th April 2031 to 12th April 2032	No	Yes
13th April 2032 to 12th April 2033	No	No

Note: Preventive Health Check-up does NOT carry forward if not claimed in the policy year where Insured person is eligible to avail the same.

SECTION C. EXCLUSIONS & WAITING PERIOD

1. Standard Waiting Period

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

i. 30-day waiting period: Code – Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified disease/procedure waiting period: Code – Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident or underlying cause is cancer(s).

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/migration stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures: -

Sl. No.	Organ / Organ System	Illness/Diagnosis (irrespective of treatments medical or surgical)	Surgeries/ procedure (irrespective of any illness / diagnosis other than cancers)
a.	Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Nasal concha resection • Nasal polypectomy • Surgery for Turbinate hypertrophy
b.	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease	Hysterectomy

		• Fibroids (fibromyoma)	
c.	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis	• Surgery for prolapsed inter vertebral disk • Joint replacement surgeries
d.	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus • Ulcer and erosion of stomach and duodenum • Gastro Esophageal Reflux Disorder (GERD) • All forms of cirrhosis (Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses	• Cholecystectomy • Surgery of hernia
e.	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	• Cataract	• NIL
g.	Others	• NIL	• Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs /disciplines whether or not described above)	• Internal tumours, cysts, nodules, polyps, skin tumours	• NIL

iii. Pre-Existing Diseases: Code – Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct

complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the insured person is continuously covered without any break as defined under the applicable norms on portability/migration stipulated by IRDAI Regulations , then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

2. Standard General exclusions

We will not pay for any claim which is caused by, arising from or attributable to:

Non-Medical Exclusions	**1)** 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. **2)** 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.
Medical Exclusions	**3)** Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12 **4)** Obesity/ Weight Control: Code – Excl06 Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: **i.** Surgery to be conducted is upon the advice of the Doctor **ii.** The surgery/Procedure conducted should be supported by clinical protocols **iii.** The member has to be 18 years of age or older and **iv.** Body Mass Index (BMI); **a)** greater than or equal to 40 or **b)** greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: **i.** Obesity-related cardiomyopathy **ii.** Coronary heart disease **iii.** Severe Sleep Apnoea **iv.** Uncontrolled Type2 Diabetes **5)** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres: Code – Excl15

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

7) 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.

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

9) Investigation & Evaluation: Code – Excl04
- **a)** Expenses related to any admission primarily for diagnostics 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.

10) Rest Cure, rehabilitation and respite care: Code – Excl05
- **a)** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
  - **i.** 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.
  - **ii.** Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

11) Treatments received in heath 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

12) 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

13) Maternity (except to the extent provided for under Section B.3)a):Code – Excl18
- **i.** Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

	ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period. **14)** Sterility and Infertility: Code – Excl17 Expenses related to sterility and infertility. This includes: **i.** Any type of contraception, sterilization **ii.** Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI **iii.** Gestational Surrogacy **iv.** Reversal of sterilization **15)** Excluded Providers: Code – Excl11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

3. Specific Exclusions

Non-Medical Exclusions	**1)** Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. **2)** Intentional self injury or attempted suicide while sane or insane. **3)** Any Insured Person's participation or involvement in naval, military or air force operation.
Medical Exclusions	**4)** Prosthetic and other devices which are self-detachable/removable without surgery involving anaesthesia **5)** Treatment availed outside India. **6)** Treatment at a healthcare facility that is not a Hospital or Day Care Centre **7)** Circumcisions (unless necessitated by Illness or injury and forming part of treatment) **8)** Any Non allopathic treatment except to the extent of coverage provided for under 'Ayush benefit'. **9)** Conditions for which treatment could have been done on an outpatient basis without any Hospitalization. **10)** Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment) **11)** Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated

	expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips **12)** Sleep apnoea. **13)** Congenital external diseases, defects or anomalies **14)** Expenses incurred by the insured on organ donation **15)** Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. **16)** Dental treatment and surgery of any kind, unless requiring Hospitalisation **17)** Any non medical expenses mentioned in List 1 of Annexure I **18)** Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. **19)** Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. **20)** Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. **21)** Drugs or treatments which are not supported by a prescription. **22)** Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured. **23)** Admission for administration of Intra-articular or Intra-lesional injections, Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc.) or IV immunoglobulin infusion

SECTION D. GENERAL CONDITIONS

1. Standard General Conditions

a. Conditions Precedent to admissibility 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.

b. Claims Settlement (Provision for Penal Interest)

i) The Company shall (other than cashless), settle or reject a claim,as the case may be, within 15 days from the date of receipt of intimation of claims..

ii) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the Bank Rate.(Explanation: "Bank rate" shall mean rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1 st day of the financial year in which the claim has fallen due)

iii) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

iv) We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).

v) The assignment of benefits of the policy shall be subject to applicable law.

vi) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an emergency.

vii) Healthcare Advisory Benefit: We may suggest alternate Network Provider in specific cases of surgical or medical treatment, should the Insured member accept and utilize one of the alternatives suggested he would be eligible for a lump sum benefit of Rs 5000.

Please note: The acceptance of our recommendation is not obligatory on the Insured member and We are not liable for any outcome of the treatment conducted at the network centre.

c. 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.

d. Multiple Policies

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

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

iii. If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

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

e. Renewal of Policy

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

a) Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.

b) The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

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

d) The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.

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

company

f. Cancellation

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

g. 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 thirty 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.

h. 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.

i. 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.

j. Moratorium Period

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

k. Portability

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

l. 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.

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

The Company, as per IRDAI regulations, may revise or modify the terms of the Policy including the premium rates. The Policyholder shall be notified 30 days before the changes are effected.

n. 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.

o. 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.

p. Premium Payment in Instalments

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

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

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

ii. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

iii. 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 instalment is opted through auto Debit/ECS facility, Electronic Clearing Service (ECS) Mandate form needs to be completely filled & signed by the Insured Person.

ii. The Premium amount which would be auto debited & frequency of instalment should be duly filled in the ECS Mandate form.

iii. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.

iv. The Company should be informed at least 15 days prior to the due date of instalment premium if the Insured Person wishes to discontinue the ECS facility.

v. Non-payment of premium on due date as opted by the Insured Person in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the Policy.

q. Grievance Redressal Procedure

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

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

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

Women	-	022 6158 2055

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

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

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

2. Specific General Terms & Conditions

a. Geography

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

The premium will be computed basis the city of residence provided by the insured person in the application form. The premium that would be applicable zone wise and the cities defined in each zone are as under:

a. Tier 1: Delhi, Surat, Gurugram, Faridabad, Ghaziabad, Greater Noida.
b. Tier 2: Mumbai, Mumbai Suburban, Thane, Navi Mumbai, Ahmedabad, Vadodara.
c. Tier 3: Nashik, Rest of NCR, Amritsar, Ahmednagar, Mathura, Aligarh.
d. Tier 4: Kolkata, Rest of Gujarat, Telangana, Agra, Ludhiana, Beed, Jalgaon, Indore, Gwalior.
e. Tier 5: Rest of Maharashtra, Rest of Uttar Pradesh, Rest of Madhya Pradesh, Rest of Rajasthan, Rest of Haryana, Howrah, Hooghly, North 24 Parganas, South 24 Parganas.
f. Tier 6: Rest of India.

No co-payment shall apply if Insured Person from a lower tier avails a treatment in higher tier. For example: Insured Person buying policy from Tier 4 can avail treatment in Tier 1 without any co-payment

The premium will be modified in case of mid -term address change involving migration from one zone to another and would be calculated on pro-rata basis.

b. Insured Person

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

Any Insured Person in the policy has the option to migrate to similar indemnity health insurance policy available with us at the time of renewal subject to underwriting with continuity benefit of waiver of waiting period, provided the policy has been maintained without a break

as per portability/migration guidelines.

If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will return a rateable part of the premium received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

c. Loadings & Discounts

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 200% per diagnosis / medical condition and an overall risk loading of over 300% per person.

These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the receipt of such counter offer letter.

In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after getting Your consent and additional premium (if any). Please visit our nearest branch to refer our underwriting guidelines if required.

We will provide a Family Discount of 5% if 2 members are covered and 10% if 3 or more family members are covered under a single Easy Health Individual Health Insurance Plan.

An additional discount of 6% will be provided if insured person is paying two year premium, in advance as a single premium.

In case of Family Floater policies Floater discount of 55% will be applied on all the members except the oldest member. These discounts shall be applicable at inception and renewal of the policy.

d. Notification of Claim

	Treatment, Consultation or Procedure:	We must be notified:
i.	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii.	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency:	Within 24 hours of the start of the Insured Person's Hospitalisation.
iii.	For all benefits which are contingent on Our prior acceptance of a claim under Section B-1)a):	Within 7 days of the Insured Person's discharge post-hospitalisation.

e. Cashless Service:

	Treatment,	**Treatment,**	**Cashless Service is**	**We must be given**

	Consultation or Procedure:	**Consultation or Procedure Taken at:**	**Available:**	**notice that the Insured Person wishes to take advantage of the cashless service** accompanied by full particulars.
i.	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or hospitalisation.
ii.	If Any treatment, consultation or procedure for which a claim may be made taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation.

f. Supporting Documentation & Examination

The Insured Person or someone claiming on your behalf shall provide Us with any documentation, medical records and information We A may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include but is not limited to the following:

i) Our claim form, duly completed and signed for on behalf of the Insured Person.

ii) Original bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

iii) All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries

iv) A precise diagnosis of the treatment for which a claim is made.

v) A detailed list of the individual medical services and treatments provided and a unit price for each.

vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice

vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made

viii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection

ix) Treating doctors certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident

x) Copy of settlement letter from other insurance company or TPA

xi) Stickers and invoice of implants used during surgery

xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident

xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

xiv) Legal heir certificate

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

h. 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:

- Cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule and
- The claim under such Policy if any, shall be rejected/repudiated forthwith.

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

a) Permanently exclude the disease/condition and continue with the Policy

b) Incorporate additional waiting period of not exceeding 3 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

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

i. Endorsements

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

j. Change of Policyholder

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

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

k. Notices

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

i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement

ii) Us, shall be delivered to Our address specified in the Schedule.

iii) No insurance agents, brokers or other person/ entity is authorised to receive any notice on Our behalf.

l. Dispute Resolution Clause

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

m. Favourable Claims Experience Discount

This policy is eligible for a discount on premium basis Hospitalization claims (which includes either In-patient Care or Day Care treatment) made in the last 2 policy years.

i. For new buyers of Health Insurance policy where-in NO claim experience is available for all insured person(s), discount eligibility shall be as below:

Premium applicable for (policy year)	**1st Year**	**2nd Year**
Discount (%) applicable on premium of each policy year basis policy tenure opted	20%	15%

ii. For policies wherein all Insured Persons have served only 1 year in a health insurance policy (either with HDFC ERGO or with any other insurer), discount eligibility shall be as below:

Premium applicable for (policy year)		**1st Year**	**2nd Year**
Discount (%) applicable on premium of each policy year basis policy tenure opted	**In case of claim in last policy year**	9%	9%
	In case of NO claim in last policy year	15%	15%

Note: As 'Favourable claims experience discount' is calculated at policy level, hence, eligibility of discount shall be on the basis of those Insured Person(s) who have claims experience under a health insurance policy.

iii. For policies wherein any Insured Person(s) have served 2 or more years in a health insurance policy (either with HDFC ERGO or with any other insurer), discount eligibility shall be as below:

Premium applicable for (policy year)		1st Year	2nd Year
Discount (%) applicable on premium of each policy year basis policy tenure opted	**In case of claim in both last policy year & year prior to last policy year**	0%	0%
	In case of claim in EITHER last policy year OR year prior to last policy year	9%	9%
	In case of NO claim in last policy year & NO claim in year prior to last policy year	15%	15%

Notes pertaining to calculation and applicability of Favourable Claims Experience Discount

a. For calculation of favourable claims experience discount, a claim in policy year shall mean any hospitalization related claim made during the policy year irrespective of the claim amount and number of such claims.

b. Utilization of preventive health check-up shall not be considered a claim for the purpose of calculating the favourable claims experience discount.

c. Hospitalization claim(s) made either within India or outside India shall be considered as claims for calculation of 'Favourable claims experience discount'.

d. If in a policy, an insured person is aged 60 years or above at the start of a policy year then only that insured person shall not be eligible for Favourable Claims Experience Discount for such policy year(s).

e. After issuance of renewal notice, if a hospitalization claim has been made in the remainder of the policy year, such claims shall be considered for calculation of 'Favourable claims experience discount' in the next renewal.

f. In case of any misrepresentation or non-disclosure relating to previous claim history of the Insured Persons in the proposal form or underwriting documents, the Company may recover the discounted premium offered earlier either from the Policy renewal premium or set-off against claim. The Company may also cancel the Policy in accordance with Standard General Conditions - (f) of the policy.

Illustration pertaining to calculation and applicability of Favourable Claims Experience Discount:

If a new customer with NO prior claims experience, aged 40 years and residing in Mumbai buys a 2-year Easy Health- Exclusive Plan of 10L base sum insured then,

Premium applicable for	Premium Amount (₹)	Favourable claims experience discount (%)	Effective premium after discount (₹)
1st policy year	22,168	20%	22,168 – 4,434 = 17,734
2nd policy year	22,630	15%	22,630 – 3,395 = 19,235
Premium after Favourable claims experience discount (₹)			36,969

n. Calculation of Premium in case of Family Floater policies

In case of Family Floater Policies Floater a discount of 55% will be applied on premium of all members insured in the policy except the oldest member

Illustration for calculation of premium in case of family floater policies

Plan: 2A + 2C, Tier 1 and Sum Insured of INR 5,00,000 for Standard Plan where all Insured persons are new buyers of Health Insurance for 1 year tenure.					
Member	**Age**	**Illustrative Individual Gross Premium (Excl. GST) (A)**	**Premium after Favourable claims experience discount 20% (Rs.) (B)**	**Discount (C)**	**Individual Premium after floater discount (D = C*(1-C))**
Self	42	22,979	18,383	0%	18,383
Spouse	39	21,909	17,527	55%	7,887
Child 1	10	11,097	8,878	55%	3,995
Child 2	8	10,793	8,634	55%	3,885
Total Family Floater Gross Premium (Excl. GST) for 2A 2C in respect of the above-mentioned model points					**34,151**

SECTION E. OTHER TERMS & CONDITIONS

1. Claim Related Information

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

Claim Intimation:	Customer Service No. 022-62346234 / 0120-62346234 Email: healthclaims@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

Additional Note: Please refer to the list of empanelled network centers on our website or the list provided in the welcome kit.

ANNEXURE A

Ombudsman Details

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

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD **Shri Collu Vikas Rao** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU **Ms Neerja Kapur** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in	Karnataka.
BHOPAL **Shri Ajay Kumar** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: oio.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR **Shri Bimbadhar Pradhan** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003	Odisha.

Email: oio.bhubaneswar@cioins.co.in	
CHANDIGARH **Ms Alka Jha** **Insurance Ombudsman** **Office of The Insurance Ombudsman,** Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: oio.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI **Shri K.Vinayak Rao** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: oio.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
DELHI **Ms Sunita Sharma** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: oio.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI **Shri Ajay Kumar Sharma** **Insurance Ombudsman** **Office of the Insurance Ombudsman,** Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

For updated list of Insurance Ombudsman details including Name, Address and jurisdiction, kindly visit: https://irdai.gov.in/ombudsman
Alternatively, you can also access the details by visiting: https://www.coins.co.in/Ombudsman.

Schedule of Benefits – Easy Health Individual

	Standard	Exclusive		
Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	1.00, 1.50, 2.00, 2.50, 3.00, 4.00, 5.00,7.5,10,15	3.00, 4.00, 5.00	7.50,10.00	15.00,20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered	Covered		
1 b) Pre-hospitalization	Covered	Covered		
1 c) Post-hospitalization	Covered	Covered		
1 d) Day Care Procedures	Covered	Covered		
1 e) Domiciliary Treatment	Covered	Covered		
1 f) Organ Donor	Covered	Covered		
1 g) Emergency Ambulance	Upto Rs.2000 per hospitalisation	Upto Rs.2000 per hospitalisation		
1 h) Ayush Benefit	Covered upto Sum Insured	Covered upto Sum Insured		Covered upto Sum Insured
1 i) Daily Cash for choosing Shared Accommodation	Rs.500 per day, Maximum Rs.3,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
2 a) Daily Cash for accompanying an insured child	Not Covered	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.800 per day, Maximum Rs.24,000
2 b) Newborn baby	Not Covered	Additional Benefit on payment of additional premium		
2 c) Recovery Benefit	Not Covered	Not Covered		Rs 10,000
2 d) Emergency Air Ambulance	Not covered	Not covered		Upto Rs.2.5 Lacs per hospitalisation
3 a) Maternity Expenses	Not Covered	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (* Including Pre/Post Natal limit of Rs.1,500 and New Born limit of Rs.2,000) [Waiting Period of 6 years]	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (* Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500) [Waiting Period of 6 years]	Normal Delivery Rs. 30,000* Caesarean Delivery Rs. 50,000* (* Including Pre/Post Natal limit of Rs. 5,000 and New Born limit of Rs.5,000) [Waiting Period of 4 Years]

4 Critical Illness (Optional benefit)	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured subject to minimum of Rs 100,000 upto a maximum of Rs. 10 Lacs	Optional, if opted then the Critical Illness Sum Insured will be 50% or 100% of In-patient Sum Insured	Optional, if opted then the Critical Illness Sum Insured will be 50% or 100% of In-patient Sum Insured upto a maximum of Rs 10 Lacs
5.1. Cumulative Bonus	10% of the Basic Sum Insured maximum upto 100% post completion of each policy year irrespective of claims		
5.2. Stay Active	Upto 8% discount on renewal premium subject to insured member achieving the average number of steps in each time interval prescribed in the grid by either walking or running regularly to keep fit. Dependent children covered will not be considered for calculation of average steps.		
5.3. Health Checkup	Upto 1% of Base Sum Insured per Insured Person upto Rs.5000, only once at the end of a block of every continuous four claim free years.	Upto 1% of Base Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous three policy years	
Benefits under 5.1, 5.2, 5.3 are subject to pre-authorisation by HDFC ERGO General Insurance Limited			

Schedule of Benefits – Easy Health Family

	Standard	Exclusive		
Sum Insured per Policy per Policy Year (Rs. in Lakh)	2.00, 3.00, 4.00, 5.00,7.50,10.00,15.00	3.00, 4.00, 5.00	7.50,10.00	15.00,20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered	Covered		
1 b) Pre-hospitalization	Covered	Covered		
1 c) Post-hospitalization	Covered	Covered		
1 d) Day Care Procedures	Covered	Covered		
1 e) Domiciliary Treatment	Covered	Covered		
1 f) Organ Donor	Covered	Covered		
1 g) Emergency Ambulance	Upto Rs.2000 per hospitalisation	Upto Rs.2000 per hospitalisation		
1 h) Ayush Benefit	Covered upto Sum Insured	Covered upto Sum Insured		Covered upto Sum Insured
1 i) Daily Cash for choosing Shared Accommodation	Rs.500 per day, Maximum Rs.3,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
2 a) Daily Cash for accompanying an insured child	Not Covered	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.800 per day, Maximum Rs.24,000
2 b) Newborn baby	Not Covered	Additional Benefit on payment of additional premium		
2 c) Recovery Benefit	Not Covered	Not Covered		Rs 10,000
2 d) Emergency Air Ambulance	Not covered	Not covered		Upto Rs.2.5 Lacs per hospitalisation
3 a) Maternity Expenses	Not Covered	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (* Including Pre/Post Natal limit of Rs.1,500 and New Born limit of Rs.2,000) [Waiting Period 4 years]	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (* Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500) [Waiting Period 4 years]	Normal Delivery Rs. 30,000* Caesarean Delivery Rs. 50,000* (* Including Pre/Post Natal limit of Rs. 5,000 and New Born limit of Rs.5,000) [Waiting Period of 3 Years]
4 Critical Illness (Optional benefit)	Optional, if opted then the Critical Illness Sum	Optional, if opted then the Critical Illness Sum		Optional, if opted then the Critical Illness Sum

	Insured 50% or 100% of In-patient Sum Insured subject to minimum of Rs 100,000 upto a maximum of Rs 10 Lacs	Insured will be 50% or 100% of In-patient Sum Insured	Insured will be 50% or 100% of In-patient Sum Insured upto a maximum of Rs 10 Lacs
5.1. Cumulative bonus	10% of the Basic Sum Insured maximum upto 100% post completion of each policy year irrespective of claims		
5.2. Stay Active	Upto 8% discount on renewal premium subject to insured member achieving the average number of steps in each time interval prescribed in the grid by either walking or running regularly to keep fit. In a floater policy it would be an average of all adult members covered. Dependent children covered will not be considered for calculation of average steps.		
5.3. Health Checkup	Upto 1% of Base Sum Insured per Policy upto Rs.5000, only once at the end of a block of every continuous four claim free years	Upto 1% of Base Sum Insured per Policy subject to a Maximum of Rs. 5,000 per Insured Person, only once at the end of a block of every continuous three policy years.	
Benefits under 5.1,5.2,5.3 are subject to pre-authorisation by HDFC ERGO General Insurance Limited			

Annexure I

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

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE

34	WALKING AIDS CHARGES	68	VASOFIX SAFETY

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG

37	PULSEOXYMETER CHARGES

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

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

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

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

16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG

Notes:

- Claims are being processed based on the applicable policy terms and conditions, even if these charges are billed separately by the health care providers.
- Items mentioned under List II, List III and List IV are allowed if these are within the scope of coverage