HDFC ERGO General Insurance Company Limited

Policy Wording

Group Mediclaim Insurance

Table of Contents

Operating Clause

We will provide Insurance coverage to the Insured Person(s) under this Policy up to Sum Insured including Restore/Double Restore, Cumulative Bonus as applicable and subject to waiting periods, limits, Sub-limits, Co-payment, Deductible, Aggregate Deductible as specified in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.The Policy is based on statements, disclosures, declarations made in the Proposal form/Enrollment form and Medical reports.

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

A. DEFINITIONS

1. Standard Definitions applicable to the Policy

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

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

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

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

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

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

all the following criterion:

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

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

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

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

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

Def. 7 **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body

Def. 8 **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A Co-Payment does not reduce the Sum Insured

Def. 9 **Coverage Period** means the Period between the Coverage effective date and the expiry date applicable to Insured Person specified in the Policy Schedule/Certificate of Insurance.

Def. 10 **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 11 **Day care Centre** means any institution established for Day Care Treatment of Illness and / or injuries or a medical set -up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 12 **Day Care Treatment/** Procedures means those medical treatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24

hours because of technological advancement, and

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

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

Def. 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, fillings (where appropriate), crowns, extractions and surgery

Def. 15 **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. 16 **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury whichin the normal course would require care and treatment at a Hospital but is actually takenwhile confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

ii. the patient takes treatment at home on account of non-availability of room in a Hospital

Def. 17 **Emergency Care** means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health.

Def. 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 ofIllness and/or injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,

- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 20 **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 21 **Illness/Illnesses** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

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

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

1. it needs on-going or long-term monitoring through consultations, examinations, check-ups, and /or tests

2. it needs on-going or long-term control or relief of symptoms

3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

4. it continues indefinitely

5. it recurs or is likely to recur

Def. 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 **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. 25 **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 26 **Maternity Expenses** means

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and

caesarean section incurred during Hospitalization).

b. Expenses towards lawful medical termination of pregnancy during the policy Period.

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

Def. 28 **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 29 **Medically Necessary treatment** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 30 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 31 **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. 32 **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 33 **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

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

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

Def. 36 **OPD Treatment** - OPD treatment means the one in which the Insured visits a clinic / Hospitalor associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 37 **Portability** means 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. 38 **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. 39 **Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:

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

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

Def. 40 **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:

i. Such 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. 41 **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 42 **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods

Def. 43 **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses

Def. 44 **Reasonable and Customary** Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services ,taking into account the nature of Illness/ Injury involved.

Def. 45 **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a medical practitioner.

Def. 46 **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

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 at the Policy Commencement Date.

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

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

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

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

Def. 7 **Bank rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 8 **Base Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for respective Cover during the life time of the Policy.

Def. 9 **Break in Policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

Def. 10 **Biological attack** or weapons the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

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

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

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

Schedule/Certificate of Insurance

Def. 14 **Coma/Comatose State** means a state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

iv. The condition has to be confirmed by a specialist medical practitioner.

v. Coma resulting directly from alcohol or drug abuse is excluded.

Def. 15 **Dependent Child/Children** means living dependent child or children of Insured Person up to age of 25 years as on date of Injury, including legally adopted and step- children.

Def. 16 **Dependents** means only the family members listed below:

a. Your legally married spouse as long as she continues to be married to You

b. Your children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households;

c. Your natural parents or parents that have legally adopted You, and Your parent in laws

Def. 17 **Dependent Parents** means Your natural parents, parents that have legally adopted you or Your parents in law.

Def. 18 **Family Floater** means a Policy described as such in the Policy Schedule where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date on floater Sum Insured basis.

Def. 19 **Immediate Family** mean an Insured Person's Spouse; children; children-in-law, siblings; siblings-in-law; parents; parents-in-law; grandparents; grandchildren; legal guardian, ward, step or adopted children; step-parents; aunts, uncles; nieces, and nephews.

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

Def. 21 **Life threatening situation** shall mean a serious medical condition or symptom resulting from Injury or Illness which is not pre-existing disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

Def. 22 **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. 23 **Medical Consultation** is a procedure where a Medical Practitioner reviews an Insured Person's medical history, medically examines the Insured Person and makes recommendations as to care and treatment.

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

Def. 25 **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

Def. 26 **Mental Health Nurse** means a person with a diploma or degree in general nursing or diploma or degree in psychiatric nursing recognised by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State

Def. 27 **Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium

Def. 28 **Preventive Health Check-up**: Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Def. 29 **Non-Medical Expenses:** Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergo.com

Def. 30 **Nuclear attack** means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

Def. 31 **Period of Insurance** means the period between the Coverage Commencement Date and the Expiry Date specified in the Policy Schedule/Certificate of Insurance under the Policy with the Company under which Insured Person is covered.

Def. 32 **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), and the Policy Schedule (as the same may be amended from time to time).

Def. 33 **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule. ForInsured Person it means Period of Insurance as specified in the Certificate of Insurance or Endorsement

Def. 34 **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 35 Policy Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to (Schedule of coverage), including any Annexure and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 36 **Policy Year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

Def. 37 **Second Medical Opinion** means a procedure where by upon request of Insured Person, an independent Medical Practitioner reviews and opines on treating Medical Practitioner's recommendation as to care and treatment of Insured Person by reviewing Insured Person's medical status and history

Def. 38 **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Year

Def. 39 **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

Def. 40 **Time Deductible** means a cost sharing requirement under a health insurance Policy that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer. A Time Deductible does not reduce the Sum Insured

Def. 41 **We/Our/Us/Insurer/Company** means the HDFC ERGO General Insurance Company Limited

Def. 42 **You/Your** means the Insured Person named in the Policy Schedule who is insured under the Policy

3. **Standard Definitions-Major Illnesses –** applicable to optional cover 12 under Section B.II

1. **Cancer of specified severity**

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

The following are excluded:

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1,

CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. Open Chest CABG

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

II. The following are excluded:

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

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

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

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

b. New characteristic electrocardiogram changes

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

II. The following are excluded:

a. Other acute Coronary Syndromes

b. Any type of angina pectoris

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

4. Kidney failure requiring regular dialysis

I. End stage renal disease presenting 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. Diagnosis has to be confirmed by a specialist medical practitioner.

5. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

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

The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

6. Multiple Sclerosis with persisting symptoms

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

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

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

II. Neurological damage due to SLE is excluded.

7. Permanent Paralysis of Limbs

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

8. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

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

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

II. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

4. Standard Definitions- Critical Illnesses – applicable to optional cover 21 under Section B.II

1. Kidney failure requiring regular dialysis

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

2. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolisation from an extra cranial source.

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

II. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

3. Open Chest CABG

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

II. The following are excluded:

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

4. Cancer of specified severity

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

The following are excluded:

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or

beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

5. Encephalitis

I. Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Medical practitioner who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

6. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Medical practitioner who is a qualified specialist.

7. Total Replacement of Joints

Surgical replacement of a joint with an artificial prosthesis performed under general or regional anesthesia in a Hospital by an orthopaedic surgeon.

8. Cirrhosis of Liver

I. Cirrhosis is a late stage of scarring (fibrosis) of the liver caused by many forms of liver diseases and conditions, such as hepatitis.

II. Characterized by at least three of the following conditions: I. Jaundice ii. Ascites iii. Bleeding from esophageal varices

III. Should be certified by a hepatologist and supported by a MRI and Ultrasound and elevated Bilirubin levels.

IV. Drug or alcohol abuse leading to liver cirrhosis is excluded.

9. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area.

The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

SECTION B. COVERAGES

I. Hospitalization Expenses

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

a. Medical Expenses

i. Room Rent and boarding charges

ii. Intensive Care Unit charges

iii. Consultation fees & Nursing charges

iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges

v. Medicines, drugs and consumables

vi. Diagnostic procedures related to admissible hospitalization claim

vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

b. Pre-Hospitalization Medical Expenses Cover

We will pay for the Pre-HospitalizationMedical Expenses incurred during the 30 days immediately before Hospitalization of an Insured Person.

c. Post-Hospitalization Medical Expenses Cover

We will pay for the Post-HospitalizationMedical Expenses incurred upto 60 days from the date Insured Person is discharged from Hospital.

d. Domiciliary Hospitalization

We will pay the Medical Expenses incurred on Domiciliary Hospitalization of the Insured Person presecribed by treating Medical Practitioner.

e. Organ Donor Expenses

We will pay Medical Expenses covered under Section B.I.a towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient subject to condition that;

a. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable Laws and/or Regulations.

b. Hospitalization Claim under Section B.I.a is admissible under the coverage for the Insured

Person

c. The Organ Donor's Pre-Hospitalization and Post-Hospitalization Medical Expenses are excluded under the Policy.

d. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Coverage.

f. Day Care Procedures

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

g. Road Ambulance Cover

For each admissible Claim under Section B.I.a and B.I.f, We will pay for expenses incurred on Road Ambulance Services if Insured Person is required;

i. to be transferred to the nearest Hospital following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)

ii. or from one Hospital to another Hospital

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

II. Optional Covers

Insuring Clause

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that We will pay/restrict the Medical Expenses under below listed Covers subject to waiting periods and limits as specified in the Schedule of Coverage on the PolicySchedule/Certificate of Insurance.

Subject to otherwise all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and upto the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

1. Pre-Existing Disease Waiting period Modification Option

On availing this option, Waiting Periods listed under Section B.I.i shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

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

2. Specific Illness Waiting period Modification Option

On availing this option, Waiting Periods listed under Section B.I.ii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

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

3. Modification of General Waiting Period

On availing this option, General Waiting Period of 30 days listed under Section B.I.iii shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

By availing this option, General Waiting Period of 30 days will be waived off even in case of claims due to illnesses.

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

4. Modification of Pre and Post Hospitalization Medical Expenses

On availing this option, Pre and Post Hospitalization Medical Expenses limit specified under Section B.I.b and B.I.c respectively shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

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

5. Room Rent and ICU Modification Option

On availing this option, Room Rent and ICU limitsunder Section B.I.a shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

Proportionate Deduction

In case Room Rent during Hospitalization of InsuredPerson exceeds the aforesaid limits, the reimbursement/payment of Room Rent charges including all Associated Medical Expenses incurred at Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. This condition is not applicable in respect of Hospitals where differential billing for Associated Medical Expenses is not followed based on Room Rent.

6. Road Ambulance Modification Option

On availing this option, Road Ambulancelimit specified under Section B.I.g shall stand modified as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

7. Hospital Cash

i. Hospital Cash

If Insured Person contracts Illnessor sustains Injuryduring Period of Insurance, which results in Medically Necessary;

i. Hospitalization

ii. Domiciliary Hospitalization

iii. Hospitalization for Alternative Treatments

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

The payment is subject toTime Deductiblespecified in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. Specific Conditions applicable to Hospital Cash

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

8. Preventive Health Check Up

We will indemnify the Insured Person towards the cost of Preventive Health Check – Up, up to the limit mentioned on the Schedule of Coverage in the Policy Schedule/Certifiate of Insurance.

Other terms and Conditions applicable to this Coverage

- The Coverage will be applicable as per the eligibility as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.
- In case of Annual Eligibility, the percentage and limit will be calculated on expiring Coverage SumInsured and will be only applicable to Insured Person covered under expiring Coverage, subject to no claim under Base Coverage.
- In case of Eligibility at the end of each block of continuous three years, the percentage and limit will be calculated on Average Sum Insured during block of three years and will be only applicable to Insured Person covered for all previous 3 years.
- Claim under this Cover does not impact the Sum Insured or the eligibility for Cumulative Bonus.
- The test reports received under this Coverage will not be utilized for re-underwriting the expiring coverage of Insured Person

9. Co-Payment

On availing this option, Co-Payment as mentioned in the Schedule of Coverage on the PolicySchedule/Certificate of Insurance will be applied on each and every admissible claim.

10. AlternativeTreatment

We will pay Medical Expenses covered under Section B.I, only on Medically Necessary In-patient care treatment of the Insured Person in an AYUSH Hospital upto the Sum Insured for following Alternative Treatments prescribed by Medical Practitioner:

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

Note : Alternative Treatment is no longer an optional cover. Basis CIR. Ref. IRDAI/HLT/CIR/GDL/31/01/2024 issued by IRDAI, all Insured Persons shall be covered by default for In-patient care expenses under this cover upto Sum Insured of Section B.I. (Hospitalization Expenses).

Details mentioned in the Policy Schedule against this cover shall be superceded by the above wordings.

11. Deletion of Domiciliary Hospitalization

On availing this option, Domiciliary Hospitalization under Section B.I.dshall stand deleted under the Policy.

12. Second Medical Opinion for Major Illness

We will pay expenses incurred towards Second Medical Opinion availed from Medical Practitioner in respect of Major Illness listed below through our Network Provider.

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

Major Illness Covered			
1	Cancer of specified severity	5	Major Organ/Bone Marrow Transplant
2	Open Chest CABG	6	Multiple Sclerosis with Persisting Symptoms
3	Myocardial Infarction(First Heart Attack of specific severity)	7	Permanent Paralysis of Limbs
4	Kidney Failure requiring regular dialysis	8	Stroke resulting in Permanent Symptoms

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

13. Restore Benefit

In the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year irrespective of the utilization of the Cumulative Bonus, the Company shall restore the Sum Insured up to the Base Sum Insured (as applicable under the current Policy Year) for any subsequent claims admissible under Section B.I, subject to the following conditions:

a. This Benefit shall be applied only once during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.

b. The Base Sum Insured restoration under the Restore Benefit would be triggered only upon complete or partial utilization of the Base Sum Insured by the way of first claim admitted under the Policy, and be available for subsequent claims thereafter in the Policy Year, for the Insured Person.

c. In case of a family floater policy, the Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

Illustration

Number of Claim	**Claim amount**	**Available Benefit Limit**			**Admissible claim amount**	**Utilisation of Sum Insured**
		Base Sum	**Cumulative Bonus*(on**	**Restore Benefit**		

		Insured	**1st renewal)**			
1st claim	3,00,000	5,00,000	50,000	0	3,00,000	Base (partial)
2nd claim	7,00,000	2,00,000	50,000	3,00,000	5,50,000	Base (balance) + Cumulative Bonus + Restore Benefit (partial)
3rd claim	3,00,000	-	-	2,00,000	2,00,000	Restore Benefit (partial)

*if opted

Single claim in a Policy Year cannot exceed the Base Sum Insured and Cumulative Bonus (if applicable).

14. Double Restore Benefit

i. Post complete utilization of Your BaseSum Insured and Cumulative Bonus (if applicable), if You partially or completely utilize your Restore Sum Insured (as given inII.13 above), another 100% of Base Sum Insured would be added to Your Restored Sum Insured available to all Insured Persons for claims under the Coverage during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the BaseSum Insured.

Conditions for Double Restore benefit:

a. The Restore or Double Restore Sum Insured will be applied only once during a Policy Year

b. If the Restore or Double Restore Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

c. In case of a Family Floater Policy, Restore or Double Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

d. The Restore or Double Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section B.I

e. Double Restore Benefit can only be opted with Restore Benefit (Section B.II.13).

Illustration

Number of Claim	**Claim amount**	**Available Benefit Limit**				**Admissible claim amount**	**Utilisation of Sum Insured**
		Base Sum Insured	**Cumulative Bonus*(on 1st renewal)**	**Restore Benefit**	**Double Restore Benefit**		
1st claim	3,00,000	5,00,000	50,000	0	0	3,00,000	Base (partial)
2nd claim	7,00,000	2,00,000	50,000	3,00,000	0	5,50,000	Base (balance) + Cumulative Bonus + Restore Benefit

							(partial)
3rd claim	6,00,000	-	-	2,00,000	3,00,000	5,00,000	Restore Benefit (partial) + Double Restore Benefit (partial)
4th claim	3,00,000	-	-	-	2,00,000	2,00,000	Restore Benefit (partial) + Double Restore Benefit (partial)

*if opted

15. Cumulative Bonus

a. On each continuous Renewal of the Coverage with Us, We will apply percentage of Base Sum Insuredas specified in the Schedule of Coverage in the Policy Schedule/Ceritficate of Insurance under expiring Cover as Cumulative Bonus irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions: In case where the Policy is on individual basis as specified in the Policy Schedule, the CB shall be added and available individually to the Insured Person..

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

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

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

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

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

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

h. If the Policy Period is of two/three years, any CB that has accrued for the first/second Policy

Year shall be credited post completion of each Policy Year.

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

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

16. Maternity Cover

We will payMaternity Expenses to the Insured Personunder Section B.I.a,incurredduring the Policy Period.The Coverage is subject to the waiting periods and limits as mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

On opting this cover, General Exclusion xv) under Section B.II. under Section C.III – Exclusions & Waiting Period, stands deleted.

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

i. Pre-Hospitalization and Post-HospitalizationMedical Expenses are not payable under this cover.

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

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

17. Pre and Post Natal Expenses

On availing this option, We will pay MedicalExpenses incurred duringPre and Post Natal period upto the Base Sum Insured.

18. Baby Cover from Day 1

We will pay Medical Expenses incurred towards Medically Necessary Treatment of a New Born Baby, as advised by the treating Medical Practitioner, up to the Base Sum Insured.

19. Infertility Cover

We will pay Medical Expenses under Section B.I.a incurred for infertility treatment, assisted reproductive treatments undertaken by Insured Person on advice of a Medical Practitioner, up to the limit mentioned in Schedule of Coverage on the Policy Schedule/Certificate of Insurance. This cover is applicable for both Male and Female Insured Person.

On opting this cover, General Exclusion xiv) under Section C.II - Waiting Period & Exclusions stands deleted.

20. Personal Accident Cover

i. Accidental Death

We will pay the Sum Insured, as specified in the Schedule of Coverage on Policy Schedule/Certificate of Insurance, if Insured Person sustains Injury during the Period of Insurance, which shall within twelve months of its occurrence be the sole and direct cause of

Death of Insured Person.

a. **Disappearance**

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

a. after the forced landing, stranding, sinking or wrecking of a conveyance in which Insured Person was known to be a passenger during Period of Insurance or;

b. after and as a result of any Catastrophic Event during Period of Insurance

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

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

Specific Conditions applicable to Accidental Death

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

ii. Permanent Disablement

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

i. Benefit Table A

S.No	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use of such Limbs)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance of Limbs)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities	100%

	essential to life without full time assistance	
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance of Limbs)	50%
12	Permanent Total Loss of Sight of one eye	50%

ii. Benefit Table B

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

iii. Benefit Table C

S.No	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use of such Limbs)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%

9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	
a)	All – one foot	15%
b)	Big – both joints	5%
c)	Big – one joint	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%

iv. Benefit Table D

S.No	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use of such Limbs)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%

8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes:	
a)	All – one foot	15%
b)	Big – both joints	5%
c)	Big – one joint	2%
d)	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%
23	Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of	75%

Terms and Conditions applicable to Permanent Disablement

i. Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to fifty percent (50%) of the BaseSum Insured subject to maximum of Sum Insured payable for the loss of the said members.

ii. Benefit under item 23 of Table D shall be determined by the independent Medical Practitioner who will certify the percentage of Base Sum Insured payable taking into consideration the nature of the Injuryand disability in conjunction with the stated percentages Base Sum Insured for more specific injuries shown in the Table of Benefits.

iii. Any claim amount admissible/paid during the year will reduce the Sum Insured payable for the Cover in respect of subsequent claims.

iv. The Coverage under this Section terminates on admissibility of Claim(s) equal to the Sum Insured. The Company's liability during the lifetime of the Policy will not exceed the Base Sum Insured in respect of the Cover.

v. The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Base Sum Insured shown in the Table of Benefits subject to maximum of Sum Insured.

Specific Conditions applicable to Personal Accident Cover:

i. This cover is offered only on Individual Sum Insured basis.

ii. This cover shall cease to exist, for lifetime, on admissibility of Claim(s) equal to the Sum Insured under this benefit. However, such Insured Person continues to remain insured under rest of the covers in the Policy. The other Insured Persons (if any) will continue to be covered under this cover if opted.

21. Corporate Buffer

On availing this option, We will provide for a Corporate Buffer up to the limitsand terms as specified in the the Policy Schedule/Certificate of Insurance provided that;

1. All other terms and conditions of the Policy shall remain unaltered
2. The coverage under this benefit will be applicable for Insured Persons who have exhausted their Sum Insured limits

The policyholder will have an option to choose Corporate Buffer from below listed options:

Option 1: Corporate Buffer Restricted to Critical Illness (listed in Table A below) and Floater / Individual Sum Insured

Option 2: Corporate Buffer Restricted to Critical Illness (listed in Table A below) but not Restricted to Floater / Individual Sum Insured

Option 3: Corporate Buffer Restricted to Floater / Individual Sum Insured but not Restricted to Critical Illness

Option 4: Corporate Buffer – without any restriction

Table A	
S.No	**Critical Illness**
1	Kidney failure requiring regular dialysis
2	Stroke resulting in permanent symptoms
3	Open chest CABG
4	Cancer of specified severity
5	Encephalitis (Viral)

6	Brain Surgery
7	Total Replacement of Joints
8	Cirrhosis of Liver
9	Injury leading to brain surgery
10	Third Degree Burns

22. OPD Cover

We will pay theMedical Expensesincurred by the Insured Personduring Period of Insurance for a Medically necessary OPD treatment up to the limits and in accordance with terms as specified in the Scheulde of Coverage on the Policy Schedule/Certificate of Insurance.

On opting this cover, General Exclusion xiii) under Section C.III – Exclusions & Waiting Period, stands deleted.

23. Aggregate Deductible

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

24. Disease Capping

On availing this option, Claims under Section B.I.a, for specified Illnesses will be admissible upto to maximum of Sub-limits as mentioned in the Schedule of Coverage on the Policy Schedule.

SECTION C. EXCLUSION & WAITING PERIOD

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

I. Standard Waiting Periods

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

i. Pre-existing Diseases – Code – Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

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

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the Policy after the expiry of36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

ii. Specified Disease/Procedure waiting period- Code – Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.

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

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

Illnesses

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

Surgical Procedures

Adenoidectomy, tonsillectomy	**Tympanoplasty, Mastoidectomy**	**Hernia**
Dilatation and curettage (D&C)	Nasal concha resection	Surgery for prolapsed inter vertebral disc
Myomectomy for fibroids	Surgery of Genito urinary system	Surgery for varicose veins and varicose ulcers
Surgery on prostate	Cholecystectomy	Surgery for Perianal

		Abscesses
Hydrocele/Rectocele	Joint replacement surgeries	Surgery for Nasal septum deviation
Ligament, Tendon and Meniscal tear	Prolapsed Uterus	Rectal Prolapse
Endometriosis	Retinal detachment	Glaucoma
Varicocele	Hysterectomy	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries
Nasal polypectomy		

iii. 30-day waiting period – Code – Excl03

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

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

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

iv. A waiting period of 36 months shall apply for all Claims under Maternity Cover (Section B.II.16)

v. A waiting period of 36 months shall apply for all claims OPD cover (Section B.II.22)

II. Standard Permanent Exclusions

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

i) Investigation & Evaluation: Code Excl04

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

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

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

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

b) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii) Obesity/Weight control: Code – Excl06: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- **a)** Surgery to be conducted is upon the advice of the doctor
- **b)** The surgery/procedure conducted should be supported by clinical protocols
- **c)** The member has to be 18 years of age or older and
- **d)** Body Mass Index (BMI)
  - **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:
    1. Obesity related cardiomyopathy
    2. coronary heart disease
    3. severe sleep apnoea
    4. uncontrolled type2 diabetes

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

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

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

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

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

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

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

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

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

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

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

a) Any type of contraception, sterilization

b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c) Gestational Surrogacy

d) Reversal of sterilization

xv) Maternity:Code – Excl18

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

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

III. Specific Permanent Exclusions

i. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical or Biological attack or weapons, radiation of any kind.

ii. Aggregate Deductible - We are not liable for Claims/Claim amount falling within Aggregate Deductible limit if opted and as mentioned on the Schedule of Coverage in the PolicySchedule/Certificate of Insurance.

iii. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide..

iv. Any Insured Person's participation or involvement in naval, military or air force operation.

v. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").

vi. Congenital external diseases, defects or anomalies,

vii. Stem cell harvesting.

viii. Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

ix. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).

x. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

xi. Vaccination including inoculation and immunisations (Except post Animal bite treatment),

xii. Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.

xiii. OPD treatment, unless OPD Cover is opted under Section B.II.22

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

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

xvi. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.

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

SECTION D. GENERAL CONDITIONS

I. Standard General terms

a. Cancellation

a. The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

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.

b. 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.

c. 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

d. 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.

b. Premium Payment in Instalments

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

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

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

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

ii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

iii. No interest will be charged If the instalment premium is not paid on due date.

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

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

vi. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

c. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

d. 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.

e. Nomination

The Policyholderis 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 PolicySchedule/PolicyCertificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholderwhose discharge shall be treated as full and final discharge of its liability under the Policy.

f. Claim Settlement (provision for Penal Interest)

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

ii. In 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.

g. 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.

h. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

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. Multiple Policies

i. In case of multiple policies taken by an InsuredPerson during a period from one or more insurers to indemnify treatment costs, the InsuredPerson 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.

k. 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

l. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance Policy:

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

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

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

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of Material fact are within the knowledge of the Insurer.

m. 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.

n. 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.

o. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Companyby applying for Migration of the Policy atleast 30 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.

p. 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.

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

II. Standard General terms

a. Non - Disclosure or Misrepresentation

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

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

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

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

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

b) Incorporate additional waiting period of not exceeding3 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

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

The above options will not prejudice the rights of the Company to invoke cancellation under clause 1 i above.

b. Geography

This Policy only covers Medical Treatment taken within India.

c. Loadings

i. We may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.

ii. The maximum Medical Underwriting loading shall not exceed 100% Insured Person

iii. Loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum Insured. We will not apply any additional loading on Your Policy premium at Renewal based on claim experience in Your Policy.

iv. We will inform You about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the Policy only on Your acceptance within 15 days of the receipt of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

d. Grace Period

i. A Grace Period of 30 days is available for Renewal of the Coverage. Any Illness, disease or condition contracted during Grace Periodwill not be covered and will be treated as Pre-existing diseases.

ii. For Renewal received after completion of Grace Period, the Coverage would be considered as fresh without any Renewal benefits

iii. 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

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

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

e. Endorsements

The following endorsements are permissible during the Policy Period:

Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

ii. Rectification in gender of the Insured Person

iii. Rectification in relationship of the Insured Person with the Proposer

iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)

v. Change in the correspondence address of the Insured Person/Proposer(if this does not impact the premium)

vi. Change in Nominee Details

vii. Change in Height, weight, marital status (if this does not impact the premium)

viii. Change in bank details

ix. Any other non-financial endorsement

Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth

ii. Change in Height, weight

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

iv. Deletion of Insured Person on death or Marital separation

v. Any other financial endorsement

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

f. 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.

g. Communication & Notice

Policy and any communication related to the Policy shall be sent to through electronic modes or to the address of the Insured as recorded in the Policy.

SECTION E. OTHER TERMS & CONDITIONS

I. Claims Procedure

1. Notification of a Claim

Procedure	**Cashless Hospitalization**		**Reimbursement Claims**
	Emergencies	**Planned**	
Claim Intimation You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website			
Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for	1. The health card issued by Us 2. KYC documents		

claim notification	3. The Policy Number 4. Name of the Policyholder 5. Name and address of Insured Person in respect of whom the request is being made 6. Nature of the Illness/Injury and the treatment/Surgery required 7. Name and address of the attending Medical Practitioner 8. Hospital where treatment/Surgery is proposed to be taken or /Hospital where the Insured person is admitted 9. Proposed /Actual Date of admission 10. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.
Claims documents to be submitted for Hospital Cash	1. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for Hospital cash benefit 2. First consultation letter from treating Medical Practitioner 3. Certificate from treating Medical Practitioner, specifying the duration and aetiology 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
Claims documents and procedure for Second Opinion	1. Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) 2. Select Our network Medical Practitioner from whom you would prefer to take the second opinion. (Please refer our Website or call at 24X 7 Contactline to obtain the list of Our panel doctors). 3. On receipt of the complete set of documents, We will forward the same to the concerned doctor. 4. The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.
Claims documents to be submitted for Accidental Death	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Death certificate 4. Post mortem if conducted/FSL (Forensic science laboratory)report – To check for drug abuse/intoxication 5. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
Claims documents to be submitted for Permanent Disablement	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury; 4. Disability certificate from a government certified Medical Practitioner or government Hospital confirming the extent and nature of disability; 5. Discharge summary from the Hospital Medical reports, case histories,

	investigation reports,treatmentpapers as applicable. 6. Letter from treating Medical Practitioner mentioning the reason and date for disablement and confirming the disablement. 7. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable	
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the Insured person(s) iii. Nature of disease/Illness/Injury iv. Name and address of the attendingMedical Practitioner/Hospital v. Date of admission & probable date of discharge vi. Approximate Claim Expenses	Not Applicable
	Any other relevant information as required	
Process for pre-authorization	On receipt of duly filled pre authorization form and other details, We may; • Issue the authorization letter specifying the sanctioned amount, limitation, and non-payable items, if applicable Or • Reject the request for pre-authorization specifying reasons for the rejection.	Not Applicable
List of Claim documents	Not Applicable	As enlisted below
Condonation of Delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control	

2. List of documents for Reimbursement Claims

i. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by Hospital).

ii. Government approved Photo ID & Age Proof

iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents

iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of Hospitalization in any non-network hospital of HDFC ERGO GIC or certificate from Hospital authorities providing facilities available including number of beds.

v. Discharge Card / Day Care Summary / Transfer Summary

vi. Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded

vii. Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.

viii. All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization.

ix. All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre

x. All medicine / pharmacy bills along with prescription by Medical Practitioner

xi. MLC / FIR Copy – in Accidental cases only

xii. History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.

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

xiv. Pre and Post-Operative Imaging reports

xv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).

xvi. Invoice for Vaccination and payment receipt

xvii. KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Claimant carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Claimant ***

xviii. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)

xix. Settlement letter(s), copy (-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of Insured Person, the same document reuqirement would be for nominee/legal heir of Insured Person(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility

i. Cashless facility can be availed only at Our Network Provider. The complete list of Network Providers and empanelled Service Providers is available on Our website and can be obtained by contacting Us.

ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim.

iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized.

iv. We will make payment for the Cashless authorized amount directly to the Network Provider.

v. If the claim is not notified to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim

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

ii. In 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.

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

II. Customer Service & Grievance Redressal Procedure

Contact Us

	Within India	**Outside India**
Claim Intimation:	Service No. 022-62346234 / 0120-62346234 Email:healthclaims@hdfcergo.com	Global Contact No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email: healthclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh

Ombudsman_Details

The contact details of the Insurance Ombudsman offices are as below

Office Details	**Jurisdiction of Office Union Territory, District)**
AHMEDABAD **Office of the Insurance Ombudsman,** Jeevan Prakash Building, 6th floor,	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

Office Details	Jurisdiction of Office Union Territory, District)
Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	
BENGALURU **Office of the Insurance Ombudsman,** Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL **Office of the Insurance Ombudsman,** 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR **Office of the Insurance Ombudsman,** 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH **Office Of The Insurance Ombudsman,** Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI **Office of the Insurance Ombudsman,** Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
DELHI **Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Building,	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

Office Details	Jurisdiction of Office Union Territory, District)
Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	
GUWAHATI **Office of the Insurance Ombudsman,** Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD **Office of the Insurance Ombudsman,** 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR **Office of the Insurance Ombudsman,** Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI **Office of the Insurance Ombudsman,** 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA **Office of the Insurance Ombudsman,** Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW **Office of the Insurance Ombudsman,** 6th Floor, Jeevan Bhawan, Phase-II,	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh,

Office Details	Jurisdiction of Office Union Territory, District)
Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI **Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA **Office of the Insurance Ombudsman,** Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA **Office of the Insurance Ombudsman,** 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE **Office of the Insurance Ombudsman,** Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE **Office of the Insurance Ombudsman,** 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

Annexure 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

ListI V–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