HDFC ERGO General Insurance Company Limited

Policy Wording

HDFC Group Health Insurance

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HDFC Group Health Insurance

Operating Clause

We will provide Insurance coverage to the Insured Person(s) under this Policy up to Sum Insured including Cumulative Bonus as applicable and subject to waiting periods and limits as specified on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance. The Policy is based on statements, disclosures, declarations made in the Proposal form/Enrolment 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.

SECTION A. DEFINITIONS

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

I. Standard Definitions

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

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

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

a. Central or State Government AYUSH Hospital; or

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

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

i. Having at least 5 in-patient beds;

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

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

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

Def. 4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health 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. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 9. **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. 10. **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. 11. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 12. **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. 13. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

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

Def. 14. **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. 15. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def. 16. **Hospital** means any institution established for In-patient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration 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. 17. **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. 18. **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. 19. **Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 20. **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. 21. **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. 22. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 23. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 24. **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. 25. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

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

Def. 27. **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. 28. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.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. 29. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 30. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 31. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

Def. 32. **Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the Network

Def. 33. **Non-Medical Expenses** Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergo.com

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

Def. 35. **OPD Treatment** - OPD treatment means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient**.**

Def. 36. **Pre-existing disease** means any condition, ailment, injury or disease:

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

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

Def. 37. 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. 38. 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. 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.

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

Def. 3. **Age** or **Aged** means completed years as at the Policy Commencement Date.

Def. 4. **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. 5. **Bank rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 6. **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. 7. **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. 8. **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. 9. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule/Certificate of Insurance.

Def. 10. **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. 11. **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. 12. **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. 13. **Dependent Parents** means Your natural parents, parents that have legally adopted you or Your parents in law.

Def. 14. **Family Floater** means a Policy described as such in the Policy Schedule/Certificate of Insurance where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule/Certificate of Insurance are insured under this Policy as at the Commencement Date on floater Sum Insured basis.

Def. 15. **Insured Person** means You and the persons named in the Policy Schedule/Certificate of Insurance who are insured under the Policy.

Def. 16. **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. 17. **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. 18. **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. 19. **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. 20. **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. 21. **HDFC ERGO Mobile App** is proprietary App of HDFC ERGO General Insurance Company. With this App you can:

- Access Your Policy Details
  - Manage Your Policy, download Your Policy Schedule/Certificate of Insurance and access to Your e-card will always be at Your fingertips, 24 x 7.
- Policy Endorsement made easy
  - By submitting a request to us through HDFC ERGO Mobile App, you can make any

modifications in Your Policy, for e.g. change in spelling of the name, contact number etc.

- Effortless Claims Management
  - Now you can submit Your claims from the app for faster processing and track the status at Your fingertips. You can also intimate a claim using the app. You can also view Network hospitals in Your area with directions.
- Stay Active – Short Walks, Big Benefits
  - The App tracks Your steps, fitness session and lets you earn incentive on renewal discount on Your Policy.

Def. 22. **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. 23. **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. 24. **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/Certificate of Insurance (as the same may be amended from time to time).

Def. 25. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule. For Insured Person it means Period of Insurance as specified in the Certificate of Insurance or Endorsement

Def. 26. **Policyholder** means the Group Owner/Organization/association/entity/society named in the **Policy Schedule** who has concluded the terms on behalf of the Insured Persons and in whose name the Policy is issued.

Def. 27. **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. 28. **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. 29. **Sum Insured** means the sum shown in the Policy Schedule/Certificate of Insurance 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. 30. **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. 31. **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. 32. **We/Our/Us/Insurer/Company** means the HDFC ERGO General Insurance Company Limited.

Def. 33. **You/Your** means the Insured Person named in the Policy Schedule/Certificate of Insurance who is insured under the Policy.

SECTION B. BENEFITS

A. Gold Plan

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.

1. In-Patient Hospitalization

i. Room Rent and boarding charges up to 1% of Base Sum Insured , subject to a maximum limit of INR 3000 per day

ii. Intensive Care Unit charges up to 2% of Base Sum Insured

iii. Consultation fees & Nursing charges

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

v. Medicines, drugs and consumables

vi. Diagnostic procedures

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

a. Special Conditions

i. Room Rent & Proportionate deduction

In case of admission to a room at rates exceeding 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 category.

ii. Mental Illness

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

laws and Regulations.

2. Pre-Hospitalization Medical Expenses Cover

We will pay for the Pre-Hospitalization Medical Expenses incurred during the 60 days immediately before Hospitalization of an Insured Person.

3. Post-Hospitalization Medical Expenses Cover

We will pay for the Post-Hospitalization Medical Expenses incurred upto 90 days from the date Insured Person is discharged from Hospital.

4. Day Care Procedures

We will pay for the Medical Expenses under Section A1 on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment.

5. Domiciliary Hospitalization

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

6. Road Ambulance Cover

For each admissible Claim under Section A1 and A4, 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

7. Organ Donor Expenses

We will pay Medical Expenses covered under Section A1 towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient subject to condition that;

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

ii. Hospitalization Claim under Section A1 is admissible under the coverage for the Insured Person

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

iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy.

B. Platinum Plan

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.

1. In-Patient Hospitalization

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

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

a. Special Conditions

i. Mental Illness

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

2. Pre-Hospitalization Medical Expenses cover

We will pay for the Pre-Hospitalization Medical Expenses incurred during the 60 days immediately before Hospitalization of an Insured Person.

3. Post-Hospitalization Medical Expenses cover

We will pay for the Post- Hospitalization Medical Expenses incurred upto 180 days from the date Insured Person is discharged from Hospital.

4. Day Care Procedures

We will pay for the Medical Expenses under Section B1 on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment.

5. Domiciliary Hospitalization

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

6. Road Ambulance Cover

For each admissible Claim under Section B1 and B4, 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

7. Organ Donor Expenses

We will pay Medical Expenses covered under Section B1 towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient subject to condition that;

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

ii. Hospitalization Claim under Section B1 is admissible under the coverage for the Insured Person

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

iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy.

C. **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 expenses under below listed Covers subject to waiting periods and limits as specified on the Schedule of Coverage in the Policy Schedule/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. 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/Certificate 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 Sum Insured 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 years (as mentioned on the

Schedule of Coverage), 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

2. Cumulative Bonus

On each continuous Renewal of the Coverage with Us, We will apply 10% of Base Sum Insured irrespective of any claims and shall be available under the Renewed Policy as specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance under expiring policy year as Cumulative Bonus in the Coverage provided that;

i. Cumulative Bonus can be accumulated upto the limit mentioned in the Schedule of Coverage on the Policy Schedule/Certificate of Insurance.

ii. Cumulative Bonus applied will be applicable only to Insured Person(s) covered under the expiring policy year and who continue to remain insured on Renewal.

iii. In policies with a 2/3 year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.

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

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

3. Hospital Cash

If Insured Person contracts Illness or sustains Injury during 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 on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance subject to maximum number of benefit days for each continuous and completed period of 24 hours of such Hospitalization.

4. 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 A.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 Insured	Cumulative Bonus*(on 1st renewal)	Restore Benefit		
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).

5. Waiting period Modification Option

On availing this option, Waiting Periods listed under Section C.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.

6. Specific Illness Waiting period Modification Option

On availing this option, Waiting Periods listed under Section C.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.

7. Alternative Treatment

We will pay Medical Expenses covered under Section A or B as opted, only on Medically Necessary In-patient care treatment of Insured Person in Ayush Hospital upto the limit mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance 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 Gold Plan or Platinum Plan as opted.

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

SECTION C. EXCLUSIONS & WAITING PERIOD

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

I. Standard Waiting Periods

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

i) Pre-existing Diseases: Code – Excl01

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

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

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

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

ii) Specified Disease/Procedure waiting period: Code - Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. 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.Kidney stone,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	Hysterectomy	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries
Endometriosis	Prolapsed Uterus	Rectal Prolapse
Varicocele	Retinal detachment	Glaucoma
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.

II. Standard Permanent Exclusions

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

i. Investigation & Evaluation: Code - Excl04

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

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

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

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

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

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

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

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

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

d. Body Mass Index (BMI)

i. Greater than or equal to 40 or,

ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

iii. Obesity related cardiomyopathy

iv. coronary heart disease

v. severe sleep apnoea

vi. uncontrolled type2 diabetes

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

opposite sex.

v. **Cosmetic or plastic surgery:** Code – Excl08: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to 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:** Code – Excl16: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

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

   a. Any type of contraception, sterilization

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

   c. Gestational Surrogacy

d. Reversal of sterilization

xv. Maternity: Code – Excl18

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

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

III. Specific Permanent Exclusions

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

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

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

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

v. Congenital external diseases, defects or anomalies,

vi. Stem cell harvesting.

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

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

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

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

xi. 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 as annexure I and also available at www.hdfcergo.com.

xii. Treatment taken on Outpatient basis.

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

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

xv. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not

Medically Necessary; treatments or drugs not supported by a prescription.

xvi. Expenses for Artificial limbs or 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 as annexure I and also available on www.hdfcergo.com.

SECTION D. GENERAL CONDITIONS

I. Standard General Conditions

1. Cancellation

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

ii. Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

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

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

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

2. 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	Instalment Premium Option	Grace Period applicable
Option 1	Half Yearly	30 days
Option 2	Quarterly	30 days
Option 3	Monthly	15 days

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

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

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

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

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

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

Instalment premium payment through Auto Debit/ECS Facility

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

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

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

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

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

3. 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.

4. 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.

5. Nomination

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

6. 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

7. Disclaimer applicable to HDFC ERGO Mobile App and associated services

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

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

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

8. 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.

9. 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.

10. 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.

11. Multiple Policies

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

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

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

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

12. 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.

13. 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.

14. Renewal of Policy

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

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

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

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

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

v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

15. Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed Free Look period of 30 days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the Insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

16. Migration

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

17. 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.

18. Redressal of Grievance

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. Specific General Conditions

1. Grace Period

i. A Grace Period of 30 days is available for Renewal of the Coverage. Any Illness, disease or condition contracted during Grace Period will 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. 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

2. Geography

This Policy only covers Medical Treatment taken within India.

3. Loadings

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

ii. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each Insured Person

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

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.

4. 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 30 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 exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

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

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

5. Endorsements

The following endorsements are permissible during the Policy Period:

Non-Financial Endorsements – which do not affect the premium

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

ii. Rectification in gender of the Insured Person

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

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

v. Change in the correspondence address of the 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 Person shall apply in a proposal form along with birth Certificate/ marriage certificate as the case may be for addition of Insured person.

6. 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 claim notification	**i.** The health card issued by Us **ii.** KYC documents **iii.** The Policy Number **iv.** Name of the Policyholder **v.** Name and address of Insured Person **vi.** Nature of the Illness/Injury and the treatment required **vii.** Name and address of the attending Medical Practitioner **viii.** Name of Hospital for admission/treatment **ix.** Proposed /Actual Date of admission **x.** MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury).		
Hospital Cash	**i.** Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge **ii.** First consultation letter from treating Medical Practitioner **iii.** Certificate from treating Medical Practitioner, specifying the duration and aetiology **iv.** MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury). **v.** NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), **vi.** legal heir certificate in case nominee is minor.		
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 attending Medical		Not Applicable

	Practitioner/Hospital **v.** Date of admission & probable date of discharge **vi.** Approximate Claim Expenses	
	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. 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 requirement would be for nominee/legal heir of Insured Person(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remaining legal heir(s).

3. Conditions for obtaining Cashless facility

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

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

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

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

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

4. Payment of a Claim

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

Contact Us

	Within India	**Outside India**
Claim Intimation:	Service No. 022-62346234 / 0120-62346234 **Email**:healthclaims@hdfcergo.com	**Contact no:** 800 08250825 **Global Contact No** : +800 08250825 (accessible from locations outside India only) **Landline no (Chargeable)** : 0120-4507250 **Email:** travelclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, Andheri Kurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

Ombudsman Details

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, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU **Office of the Insurance Ombudsman,** Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL **Office of the Insurance Ombudsman,** 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, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
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, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
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, HARMONIC SCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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