HDFC ERGO Group Health Insurance
Policy Wording

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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 – D, Definitions.

A. 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 A.I.a 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 A.1 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 Coverage.

f. Day Care Procedures

We will pay for the **Medical Expenses** under Section A.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 A.I.a and A.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, **Waiting Periods** listed under Section B.I.iii 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.

4. Modification of Pre and Post Hospitalization Medical Expenses

On availing this option, **Pre** and **Post Hospitalization Medical Expenses** limit specified under Section A.I.b and A.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 A.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 A.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 **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 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 to**Time Deductible**specified 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 **Hospital**stays 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.
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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 I**nsured 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 A.I, on **Medically Necessary Hospitalization** of **Insured Person** in **Ayush Hospital** upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance for following **Alternative Treatments** prescribed by **Medical Practitioner**:

- Ayurvedic
- Unani
- Siddha
- Homeopathy

11. Deletion of Domiciliary Hospitalization

On availing this option, Domiciliary Hospitalization under Section A.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 HEALTH INSURANCE 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

Instant addition of 100% Base **Sum Insured** on complete or partial utilization of **Your** existing **Sum Insured** and **Cumulative Bonus** (if applicable) during the **Policy Year**. The Total amount (Base **Sum Insured**, **Cumulative Bonus** and Restore **Sum Insured**) will be available to all Insured Persons for all claims under the Coverage during the current **Policy Year** and subject to the condition that single claim in a **Policy Year** cannot exceed the sum of Base **SumInsured.** and the **Cumulative Bonus** (if applicable).

Conditions for Restore benefit:

a. The **Sum Insured** will be restored only once in a **Policy Year**.
b. If the Restored **Sum Insured** is not utilized in a **Policy Year**, it will expire.

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

14. Double Restore Benefit

i. Instant addition of 100% Base**Sum Insured** on complete or partial utilization of **Your** existing **Policy Sum Insured** and **Cumulative Bonus** (if applicable) during the **Policy Year**. The Total amount (Base **Sum Insured**, **Cumulative Bonus** and Restore **Sum Insured** when added) will be available to all Insured Persons for all claims under the Coverage during the current **Policy Year** and subject to the condition that single claim in a **Policy Year** cannot exceed the sum of Base**Sum Insured** and the **Cumulative Bonus** (if applicable).
ii. Post complete utilization of **Your** Base**Sum Insured** and **Cumulative Bonus** (if applicable), if **You** partially or completely utilize your Restore **Sum Insured** (as given in i 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 Base**Sum Insured**.

Conditions for Double Restore benefit:

a. The Restore or Double Restore **Sum Insured** will be applied only once for the **InsuredPerson** 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 A.1

15. Cumulative Bonus

On each continuous **Renewal** of the Coverage with **Us**, **We** will apply percentage of Base **Sum Insured**as specified in the Schedule of Coverage in the **Policy Schedule**/Ceritficate of Insurance under expiring Cover as **Cumulative Bonus** in the Coverage provided that;

i. There has been no claim under the Coverage in expiring year.
ii. **Cumulative Bonus** will be reduced at the same rate as accrued in the event of admissible Claim under the Coverage.
iii. **Cumulative Bonus** can be accumulated upto the limit mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

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

16. Maternity Cover

We will pay**Maternity Expenses** to the **Insured Person**under Section A.I.a,incurred during 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. What is not Covered 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 A.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 during**Pre** and **Post Natal** period upto the limits mentioned in the Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

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 limit mentioned in Schedule of Coverage on the **Policy Schedule**/Certificate of Insurance.

19. Infertility Cover

We will pay **Medical Expenses** under Section A.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 B.II - What is not Covered 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 Insured**as 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 of 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*** 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 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 ***Limb****)*	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)	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)	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 perecentage of **BaseSum Insured** payable taking into consideration the nature of the ***Injury***and disability in conjunction with the stated percentages **BaseSum 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**.

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

22. OPD Cover

We will pay the**Medical Expenses**incurred 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 xxx) under Section B.II – What is not Covered, 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 A.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.

25. Double Sum Insured for Critical Illness

We will increase the **Sum Insured** for an **Insured Person** by 100% if he is diagnosed as suffering from below listed**Critical Illness** under this Coverage, provided that:

i) The **Insured Person** is first diagnosed as suffering from a **Critical Illness** during the **Period of Insurance**, and
ii) The benefit is utilised only by the **Insured Person** diagnosed with the **Critical Illness**, and
iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

Critical Illness Covered			
1	Cancer of specified severity	3	Major Organ/Bone Marrow Transplant
2	Myocardial Infarction(First Heart Attack of specific severity)	4	Stroke resulting in Permanent Symptoms

26. Critical Illness (Benefit Based)

We will pay **Sum Insured**as specified on the Schedule of Coverage in the **Policy Schedule**/Certificate of Insurance under this Cover, if **Insured Person** suffers from **Critical Illnesses** listed below, whose diagnosis first commence/occurs after the applicable waiting period from commencement of first **Policy** with **Us**, subject to the following:

i. Waiting Period – The coverage is subject to a waiting period of 90 days from the date of inception of the first **Policy** with us.
ii. **Survival Period** - The **Insured Person** survives at least 30 days following such diagnosis.
iii. The coverage under this benefit shall cease to exist upon occurrence of any one **Critical Illness** covered for which claim is admitted by**Us**. However, **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.
iv. This cover is offered only on Individual **Sum Insured** basis.

Critical Illness Covered			
1	Cancer of specified severity	7	Major Organ/Bone Marrow Transplant
2	Open Chest CABG	8	Stroke resulting in permanent symptoms
3	Myocardial Infarction((First Heart Attack of specific severity)	9	Multiple Sclerosis with Persisting Symptoms
4	Open Heart Replacement or Repair of Heart Valves	10	Permanent Paralysis of Limbs
5	Kidney Failure requiring regular dialysis	11	Motor Neuron Disease with Permanent Symptoms
6	Coma of Specified Severity	12	Major Head Trauma

B. What is Not Covered

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. Waiting Periods

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

i) **Pre-existing Diseases – Code – Excl01**

a) Expenses related to the treatment of a **pre-existing disease** (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of sum of **Sum Insured** increase.
c) If the **Insured Person** is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the **Policy** after the expiry of 48 months for any **pre-existing disease** is subject to the same being declared at the time of application and accepted by Insurer.

ii) **Specified Disease/Procedure waiting period- Code – Excl02**

a) Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of 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

Internal Congenital diseases	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 48 months shall apply for all Claims under Maternity Cover (Section A.II.16)

v) A waiting period of 48 months shall apply for all Claims under OPD Cover (Section A.II.22)

II. 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.

xvi. 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.

xvii. 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.

xviii. Any **Insured Person** committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.

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

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

xxi. Congenital external diseases, defects or anomalies,

xxii. Stem cell harvesting.

xxiii. 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).

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

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

xxvi. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

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

xxviii. **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.hdfcergohealth.com.

xxix. OPD treatment

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

xxxi. 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.

xxxii. 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.

xxxiii. 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.hdfcergohealth.com

xxxiv. Any Claim arising due to Non-disclosure of **Pre-existingIllness** or Material fact as sought to be declared on the Proposal form.

C. 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
Claim Intimation Timelines for Critical Illness related claims	Within 15 days of the diagnosis of Critical Illness or Hospitalization		
Particulars to be provided to us for claim notification	1. The health card issued by Us 2. KYC documents 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 to be submitted for Critical Illness related claims	1. Copy of Discharge Summary / Discharge Certificate / Death Certificate (in case insured expired); 2. First consultation letter from treating Medical Practitioner 3. Medical certificate confirming diagnosis, and the treatment from Medical Practitioner 4. certificate from treating Medical Practitioner, specifying the duration and etiology 5. OT Notes in case of Surgery 6. Medical certificate from treating Medical Practitioner specifying the diagnosis and need for the surgery 7. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 8. All pathological/Histopathological and radiological Investigation Reports 9. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is		

	minor. Provide KYC (Know your customer) form along with photocopy of any one of following KYC documents for all claims amounting to Rs 1 lakh and above (Aadhaar Card, Passport, Driving License Voter ID, etc) We may require the Insured Person to undergo medical examination by Medical Practitioner authorized by Us to obtain an independent medical opinion for the processing of the claim. Any cost towards such medical examination will be borne by Us.	
Claims documents and procedure for Second Medical 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 toll free line 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 attending**Medical 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 Health Insurance Limited 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. If there are any deficiencies in the necessary claim documents which are not met or are partially met, **We** will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
iii. In the case of delay in the payment of a claim, the **Company** shall be liable to pay interest to the **Policyholder/Insured Person** from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.
iv. However, where the circumstances of a claim warrant an investigation in the opinion of the **Company**, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the **Company** shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
v. In case of delay beyond stipulated 45 days, the **Company** shall be liable to pay interest to the **Policyholder/Insured Person** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.
vi. If **We**, for any reason decide to reject the claim, the reasons regarding the rejection shall be communicated to **You** in writing within 30 days of the receipt of documents.
vii. If requested by **Us,** 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.
viii. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess **Our** liability and quantum in respect of the claim

D. Definitions

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

Def. 4. **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. 5. **Alternative treatment** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

Def. 6. **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. 7. **Associated Medical Expenses** means cconsultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anaesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def. 8. **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. 9. **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. 10. **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. 11. **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. 12. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

Def. 13. **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. 14. **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. 15. **Catastrophic Event** means and includes Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood, Inundation and Earthquake

Def. 16. **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. 17. **Commencement Date** means the commencement date of the Policy as specified in the **Policy Schedule**/Certificate of Insurance

Def. 18. **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. 19. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon

Def. 20. **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. 21. **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. 22. **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. 23. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

Def. 24. **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. 25. **Day Care Treatment/ Procedures**means those medicaltreatment, 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. 26. **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. 27. **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. 28. **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. 29. **Dependent Parents** means **Your** natural parents, parents that have legally adopted you or **Your** parents in law.

Def. 30. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 31. **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. 32. **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. 33. **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. 34. **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. 35. **Grace Period m**eans the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.

Def. 36. **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. 37. **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. 38. **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. 39. **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. 40. **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. 41. **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. 42. **Insured Person** means **You** and the persons named in the Policy Schedule who are insured under the Policy.

Def. 43. **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. 44. **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. 45. **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. 46. **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. 47. **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. 48. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 49. **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. 50. **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. 51. **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. 52. **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. 53. **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. 54. **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. 55. **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. 56. **Migration** means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def. 57. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 58. **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. 59. **Non Network**means any **Hospital**, **Day Care Centre** or other provider that is not part of the Network

Def. 60. **Non-Medical Expenses –** Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergohealth.com

Def. 61. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 62. **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. 63. **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. 64. **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. 65. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def. 66. **Pre-existing disease** means any condition, ailment, injury or disease:

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

ii. For which **Medical advice** or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

Def. 67. **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. 68. **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. 69. **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. 70. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 71. **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. 72. **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. 73. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def. 74. **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. 75. **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. 76. **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. 77. **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. 78. **Room Rent** means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the **AssociatedMedical Expenses**

Def. 79. **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. 80. **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. 81. **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. 82. **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. 83. **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. 84. **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. 85. **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.

Def. 86. **We/Our/Us/Insurer/Company** means the HDFC ERGO Health Insurance Limited

Def. 87. **You/Your** means the Insured Person named in the Policy Schedule who is insured under the Policy

2. Major/Critical Illnesses – applicable to optional cover 12, 25 and 26 under Section A.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;
ix. All tumours in the presence of HIV infection.

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. Other causes of neurological damage such as SLE and HIV are 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.

9. Coma of Specified Severity

I. 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.

II. The condition has to be confirmed by a specialist medical practitioner.
   a. Coma resulting directly from alcohol or drug abuse is excluded.

10. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or diseaseaffected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the

realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

11. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

12. Major Head Trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

i) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv) Mobility: the ability to move indoors from room to room on level surfaces;

v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi) Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

i) Spinal cord injury;

E. General Conditions

1. Non - Disclosure or Misrepresentation

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

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

2. 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**.

3. 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**.

4. Complete Discharge

Any payment to the **Policyholder**, **Insured Person** or his/ her nominees or his/ her legal representative or assignee or to the **Hospital**, as the case may be, for any benefit under the **Policy** shall be a valid discharge towards payment of claim by the **Company** to the extent of that amount for the particular claim.

5. 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 **InsuredPerson**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**.

6. Moratorium Period

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

7. Fraud

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

Any amount already paid against claims made under this **Policy** but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who 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**.

8. Geography

This **Policy** only covers Medical Treatment taken within India.

9. 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.

10.Renewal of Policy:

The **Company** shall be under no obligation to renew the **Policy**/Coverage on expiry of the period for which premium has been paid. The **Company** reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This **Policy** may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The **Company**, however, shall not be bound to give notice that the **Policy** is due for **Renewal** or to accept any **Renewal** premium. Unless renewed as herein provided, this **Policy** shall automatically terminate at the expiry of the **Policy Period/ Coverage Period.**

11.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

12.Free look period

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

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

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

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

ii. where the risk has already commenced and the option of return of the **Policy** is exercised by the **Insured Person**, a deduction towards the proportionate risk premium for period of cover **or**
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

13. Migration

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

For Detailed Guidelines on Migration, kindly refer the link

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

14. Portability

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the **Policy** renewal date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health insurance **Policy** with an Indian General/Health insurer, the proposed **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Portability**.

For Detailed Guidelines on Portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

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

16. Cancellation

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

For Policies where instalment option is not availed, We will refund premium in accordance with the table below:

Month	**% Refund**
Up to 1 month	85.0%
Up to 3 month	70.0%
Up to 6 month	45.0%
Up to 12 month	0.0%

For Policies where Premium is paid by instalment, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the **PolicyYear**. For instalment after 6 months, no refund will be payable.

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

ii. The **Company** may cancel the **Policy** at any time on grounds of misrepresentation non-disclosure of **Material Facts,** Fraud by the **Insured Person** by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of **MaterialFacts** or **Fraud**.

17. 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

ii. During such **Grace Period**, coverage will not be available from the due date of instalment premium till the date of receipt of premium by **Company**.
iii. The **Insured Person** will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated **Grace Period**.
iv. No interest will be charged If the 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**.

18.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.

19.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.

20.Nomination

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

21.Claim Settlement (provision for Penal Interest)

i. The **Company** shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
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 last necessary document to the date of payment of claim at a rate 2% above the **Bank Rate**.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the **Company**, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the

Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the **Company** shall be liable to pay interest to the **Policyholder** at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.

22. 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**.

F. Customer Service & Grievance Redressal Procedure

I. Contact Us

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

- Website : www. hdfcergohealth.com
- Toll Free : 1800-102- 0333
- Fax : 1800- 425- 4077
- Courier : Claims Department,
  HDFC ERGO General Insurance Co. Ltd
  Stellar IT Park, Tower-1
  5th floor, C-25, Sector 62
  Noida- 201301

II. Redressal of Grievance

i. In case of any grievance the **Insured Person** may contact the **Company** through:

Website: www.hdfcergohealth.com
Toll free: 1800 102 0333
Contact Details for Senior Citizen: seniorcitizen@hdfcergohealth.com
E-mail: customerservice@hdfcergohealth.com

ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

iii. 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.

Ombudsman Details

Office Details	Jurisdiction of Office Union Territory,District)

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.

Office Details	Jurisdiction of Office Union Territory,District)
Email: bimalokpal.chandigarh@ecoi.co.in	
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363	Rajasthan.

Office Details	Jurisdiction of Office Union Territory,District)
Email: Bimalokpal.jaipur@ecoi.co.in	
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad	State of Uttaranchal and the following Districts of Uttar

Office Details	Jurisdiction of Office Union Territory,District)
Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I – List of Non-Medical Expenses

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES

22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY