Mosquito Disease Protection Policy - Group

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Insuring Clause

We will provide insurance cover to the **Insured Person(s)** under this Policy up to **Sum Insured** and subject to waiting period, Co-payment and deductible/Time Deductible as mentioned on the Schedule of Coverage in the **Policy Schedule/Certificate of Insurance**.

This **Policy** is subject to statements in respect of all the Insured Persons in Proposal Form/Enrollment, declarations, payment of premium and terms and conditions of this **Policy.**

Reference to Definitions

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

Section A –Definitions

1. Standard Definitions

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

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

Def. 3. **AYUSH Hospital** 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. eaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:
    i. Having at least 5 in-patient beds;
    ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

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

i. Having qualified registered AYUSH Medical Practitioner (s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

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

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

Def. 7. **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. 8. **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. 9. **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. 10. **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. 11. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received)

Def. 12. **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. 13. **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. 14. **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. 15. **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. 16. **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. 17. **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. 18. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 19. **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. 20. **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. 21. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Medical Practitioner (Definition applicable for the treatment taken outside India)
Means a licensed medical practitioner acting within the scope of his license and who holds a degree of a recognized institution and is registered by the Authorized Medical Council of the respective country.

Def. 1. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 22. .

Def. 23. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 24. **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. 25. **Non Network**means any **Hospital**, **Day Care Centre** or other provider that is not part of the Network

Def. 26. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 27. **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. 28. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer

Def. 29. **Pre-existing disease** means any condition, ailment, injury or disease:

i. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
ii. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def. 30. **Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person , provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 31. **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. 32. **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. 33. **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. 34. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the **Associated Medical Expenses**

Def. 35. **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.

2. Specific Definitions

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

Def. 2. **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. 3. **AYUSH Treatment** refers to Medical and /or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 4. **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. 5. **Break in policy"** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

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

Def. 7. **Dependents** means only the family members listed below:

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

b) **Your** children Aged between 1 day 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. 8. **Family Floater** means a Policy described as such in the Policy Schedule of Insurance where under You and **Your** Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date.

Def. 9. **Insured Person/You/Your**means the persons named in the Policy Schedule/Certificate of Insurance.

Def. 10. **Material Fact** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk

Def. 11. **Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium

Def. 12. **HDFC ERGO Mobile App is** proprietary App of HDFC ERGO General Insurance Company. With this App you can:

- Access **Your** Policy Details
  - Now manage **Your** policy, download **Your** Policy Schedule/Certificate of Insurance and access to **Your** e-card will always be at **Your** fingertips, 24 x 7.
- Policy Endorsement made easy
  - By submitting a request to us through HDFC ERGO Mobile App, you can make any modifications in **Your** policy, for e.g. change in spelling of the name, contact number etc.
- Effortless Claims Management

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

Def. 13. **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. 14. **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. 15. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 16. **Policy Schedule/ Certificate of Insurance** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to (Schedule of coverage), including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 17. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 18. **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. 19. **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. 20. **Waiting Period** is the period where we will not be liable for a claim for specified number of days and which will apply before any benefits are payable by Us. The waiting period will be computed from the date of commencement of Policy Period.

Def. 21. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited

Def. 22. **Policyholder** means the person/Organization named in the Policy Schedule who has concluded this Policy with Us.

3– Specific Definitions- for Vector Borne Diseases

1. Dengue Fever

Diagnosis of Dengue Fever should be confirmed by a Medical Practitioner and Laboratory examination result countersigned by a pathologist/ microbiologist confirms the following:

- Immunoglobulins/PCR test showing positive results forDengue

2. Malaria

Diagnosis of Malaria should be confirmed by a Medical Practitioner with confirmatory tests indicating presence of Plasmodium Falciparum/ Vivax/ Malariae in the patient's blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

3. Other Vector Borne Diseases

a) Chikungunya

Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include

muscle pain, headache, nausea, fatigue and rash.

The diagnosis must be documented by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.

b) Japanese Encephalitis

Characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis. To confirm Japanese Encephalitis (JE) infection and to rule out other causes of encephalitis, a laboratory testing of serum or preferably cerebrospinal fluid shall be required.

The diagnosis must be confirmed by a Medical Practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

c) Kala-azar

Visceral leishmaniasis, also known as Kala-azar, is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia.

The diagnosis must be confirmed by a Medical Practitioner and by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for Kala-azar should clearly indicate the presence of this disease.

d) Lymphatic Filariasis

Commonly known as Elephantiasis, must be confirmed by a Medical Practitioner and the laboratory examination countersigned by a pathologist must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

- Lymphoedema,
- Elephantiasis,
- Scrotalswelling

Specific condition for this cover:

- Filariasis will be payable once inlifetime

e) Zika Virus

People with Zika virus disease can have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache.

A diagnosis of Zika virus infection should be confirmed by a Medical Practitioner and by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC (Centers for Disease Control and Prevention) or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results.

Section B –Benefits

B.1 Coverage

1. Vector Borne Diseases – Indemnity

We will pay under below listed covers on Medically Necessary Hospitalization of the Insured Person due to

i) Dengue Fever
ii) Malaria
iii) Other Vector Borne Diseases:

a. Chikungunya
b. Japanese Encephalitis
c. Kala-azar
d. Lymphatic Filariasis
e. Zika Virus

which is/are contracted during the **Policy Period** and as defined and opted under the Policy subject to waiting Period as specified on the Schedule of Coverage.

a) In-Patient Hospitalization Expenses

i. Room rent, boarding and Nursing charges restricted to Single AC Private Room
ii. Intensive Care Unit charges
iii. Consultation fees
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
v. Medicines, drugs and consumables
vi. Diagnostic procedures

Note pertaining specifically to AYUSH Treatments only:
Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-Patient Hospitalization Expenses' cover if undertaken in an AYUSH Hospital. However, any medical expense other than In-patient care AYUSH treatment expenses are not covered under this Policy.

Proportionate Deduction
Room Rent & Proportionate deduction: Insured Person is eligible for **Room Rent** category of up to Single Standard AC Room. In case of admission to a room exceeding the aforesaid category, the reimbursement/payment of Room Rent charges including all **Associated Medical Expenses** incurred at Hospital shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of **Room Rent** charges. This condition is not applicable in respect of **Hospitals** where differential billing for **Associated Medical Expenses** is not followed based on Room category.

Insured Person shall bear specified percentage of admissible Claim amount under each and every admissible Claim if Co-payment under Section B.1-1.1 c) is opted and specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

Health Care at Home

Insured Person has the option to avail Health Care at Home for **Medically Necessary Treatment of Illnesses** opted for and covered under Section B.1-1, if prescribed by treating **Medical Practitioner**.

This Cover can be availed through **Cashless Facility** only as procedure under Claims Procedure - Section E.

Insured Person shall bear specified percentage of admissible Claim amount under each and every admissible Claim if **Co-payment** under Section B.1-1.1 c) is opted and specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

b) Reinstatement of Sum Insured

We will add to the Sum Insured under Section B.1-1a), an amount equivalent to the admissible Claim amount under Section B.1-1a) of the Policy subject to maximum of Basic Sum Insured subject to following conditions;

a. Sum Insured reinstated under this cover can be used only for subsequent **Hospitalization** of the Insured Person during Policy Year and is not applicable for hospitalization under**Any One Illness**

b. Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

c) Pre and Post Hospitalization Cover

We will pay for **Pre Hospitalization Medical Expenses** and **Post Hospitalization Medical Expenses** up to number of days mentioned on Policy Schedule/Certificate of Insured, which are incurred on treatment of diseases for which Claim under Section B.1-1a) is admissible under the Policy.

1.1) Optional Covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that, **We** will pay the expenses/Sum Insured under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the **Policy**.

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

a) Outpatient Treatment Expenses

We will indemnify the **Insured Person** towards expenses incurred on;

i. *Outpatient Consultation*with Medical Practitioner
ii. *Diagnostic Tests*
iii. *Pharmacy*

For**MedicallyNecessary Treatment** of diseases as opted under Section B.1-1a)

Special Conditions applicable to Outpatient Treatment Expenses

If the Claim is payable under this Section and if the **Insured Person** is subsequently hospitalized within 15 days for the **Medically Necessary** treatment of same illness, entire Claim shall be admissible under Section B.1-1a) and B.1-1d) only and payable upto the Sum Insured under Section B.1-1a) and 1d).

b) Recovery Benefit

We will pay **Sum Insured** as specified on the Schedule of Coverage in the **Policy Schedule** if period of Hospitalization for Claim admissible under Section B.1, exceeds 10 continuous days.

This benefit is not applicable if Medical treatment is taken under Health Care at Home

c) Co-payment

On availing this option, Co-Payment as mentioned on the Schedule of Coverage in the **Policy Schedule** will be applied on each and every admissible claim under Section B.1-1a).

d) Waiting Period Options

On availing this option, Waiting Period will be modified as mentioned on the Schedule of Coverage in the

PolicySchedule/Certificate of Insurance will be applicable for all the Claims under the **Policy**.

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

2. Vector Borne Diseases – Benefit

a) In-patient Hospitalization Benefit

We will pay **Sum Insured** in the manner as specified in the Schedule of Coverage to an **Insured Person** due to **Medically Necessary Hospitalization** (including In-patient care AYUSH Treatment in an AYUSH Hospital) of an **Insured Person** due to;

i) Dengue Fever
ii) Malaria
iii) Other Vector Borne Diseases:
   a. Chikungunya
   b. Japanese Encephalitis
   c. Kala-azar
   d. Lymphatic Filariasis
   e. Zika Virus

which is/are contracted during the **Policy Period** and as defined and opted under the **Policy** subject to waiting Period as specified on the Schedule of Coverage

b) Reinstatement of Sum Insured

We will add to the Sum Insured under Section B.1-2a), an amount equivalent to the admissible Claim amount under Section B.1-2a) of the Policy subject to maximum of Basic Sum Insured subject to following conditions;

a. Sum Insured reinstated under this cover can be used only for subsequent **Hospitalization** of the Insured Person during Policy Year and is not applicable for Hospitalization under **Any One Illness**
b. Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

2.2) Optional Covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that, We will pay the expenses/Sum Insured under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

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

a) Outpatient Treatment Expenses

We will pay Sum Insured towards expenses incurred on;

i. *Outpatient Consultation*with Medical Practitioner
ii. *Diagnostic Tests*
iii. *Pharmacy*

For**Medically NecessaryTreatment** of diseases as opted under Section B.1-2a)

Special Conditions applicable to Outpatient Treatment Expenses

If the Claim is payable under this Section and if the Insured Person is subsequently hospitalized with in 15 days for the same illness, entire Claim shall be admissible under Section B.1-2a) only and Sum Insured is payable under Section B.1-2a) only.

b) Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance if period of Hospitalization for Claim admissible under Section B.1-2 a), exceeds 10 continuous days.

c) Time Deductible

On availing this option, **Time Deductible** as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applied on each and every admissible Claim under the Policy.

d) Waiting Period Options

On availing this option, Waiting Period will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applicable for all the Claims under the Policy.

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

e) Annual Aggregate days limit

On availing this option, the no of annual aggregate days limit will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

f) ICUmultiplier

On availing this option, the benefit amount will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance, if the Insured Person is hospitalization in ICU.

B.2– my: Health Active

The services listed below are available to all **Insured Person** through **Our Network Provider** on **Our HDFC ERGO Mobile App** only.

i. **Health Coach:**

An **Insured Person** will have access to Health Coaching services in areas as given below:

- Disease management
- Activity and fitness
- Nutrition
- Weight management.

These services will be available through **Our HDFC ERGO Mobile App** as a chat service or as a call back facility.

ii. **Wellness services**

- **Discounts:** on OPD, Pharmaceuticals, pharmacy, diagnostic centers.
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** stress management, Pregnancy Care, Work life balance management.

Disclaimer applicable to HDFC ERGO Mobile App and associated services

It is agreed and understood that Our HDFC ERGO Mobile App and Wellness services are not providing and shall not be deemed to be providing any **Medical Advice**, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

Section C – Waiting Periods and Exclusions

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

1. Standard Waiting Period & exclusion (applicable to Section B.1 (1&2))

i) **30-day waiting period – Code – Excl03:**

a) Expenses related to the treatment of any illness within 30 days from the first **Policy** commencement date shall be excluded except claims arising due to an **Accident**, provided the same are covered.
b) This exclusion shall not, however, apply if the **Insured Person** has continuous coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced **Sum Insured** in the event of granting higher **Sum Insured** subsequently.

ii) **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.

iii) **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:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

2. Specific Waiting Period & exclusion (applicable to Section B.1 (1&2))

i) Any treatment taken on Outpatient
ii) Hospitalization for treatment under any system other than allopathy & Ayush Treatments .
iii) Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

3. Additional Exclusions applicable to Section B.1- 1

3.A. Standard Exclusions

i) 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**

3.B. Specific Exclusions

i) Charges related to a Hospital stay not expressly mentioned as being covered

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

Section D – General Conditions

1. Standard General Terms

1. 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) 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 **InsuredPerson** or by his agent or the hospital/doctor/any other party acting on behalf of the **InsuredPerson**, 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.

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 (Applicable to Section B.1-1)

i. In case of multiple policies taken by an **Insured Person** during a period from one or more insurers to indemnify treatment costs, the **Insured Person** shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the **Insured Person** shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen **Policy**.
ii. **Insured Person** having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the **Sum Insured** is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.
iii. If the amount to be claimed exceeds the **Sum Insured** under a single Policy, the **Insured Person** shall have the right to choose insurer from whom he/she wants to claim the balance amount.
iv. Where an **Insured Person** has policies from more than one Insurer to cover the same risk on indemnity basis, the **Insured Person** shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

6. Moratorium Period

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

7. Migration

The**Insured Person** will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for **Migration** of the policyatleast30 days before the policy **Renewal** date as per IRDAI guidelines on **Migration**. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Migration**.

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

8. 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

FREE LOOK PERIOD

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

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to:

a. 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
b. 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

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

9. Renewal

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

i. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.
ii. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
iii. No loading shall apply on renewals based on individual claims experience
iv. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.
v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

10. Cancellation

a. The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.
Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

b. The Company may cancel the Policy at any time on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud or non-disclosure or misrepresentation.

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

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

11. Premium Payment in Instalments

If the **Insured Person** has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the **Policy Schedule**/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 installment premium due for the **Policy**.

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

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

iii. .

iv. 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**.

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

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

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

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

12. Endorsements

The following endorsements are permissible during the **Coverage Period:**

1.1. Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Insured Person (and not the complete name change)
ii. Rectification in gender of the Insured Person (if this does not impact the premium)
iii. Rectification of date of birth of the Insured Person (if this does not impact the premium)
iv. Change in the correspondence address of the Proposer(if this does not impact the premium)
v. Change in Nominee Details
vi. Change in bank details
vii. Any other non-financial endorsement

1.2. Financial Endorsements – which result in alteration in premium

i. Cancellation of Policy
ii. Any other financial endorsement

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

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

14. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the **Company** will intimate the **Insured Person** about the same 90 days prior to expiry of the **Policy**.
ii. **Insured Person** will have the option to migrate to similar health insurance product available with the **Company** at the time of **Renewal** with all the accrued continuity benefits such as waiver of Waiting Period as per IRDAI guidelines, provided the **Policy** has been maintained without a break.

15. 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**/Certificate of Insurance/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.

16. Claim Settlement (Provision for Penal Interest)

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i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, **We** will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
iii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the **Policyholder**from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the **BankRate**.
iv. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
v. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the **Policyholder**at a rate 2% above the **Bank Rate** from the date of receipt of last necessary document to the date of payment of claim.

vi. If **We**, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.
vii. If requested by **Us** and at **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 treatment of **Insured Person** 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

17. Grievance Redressal Procedure

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

Website: www.hdfcergo.com
Contact no4: 022 6234 6234 / 0120 6234 6234
Contact Details for Senior Citizen: 022 6234 6234 / 0120 6234 6234
E-mail: care@hdfcergo.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at cgo@hdfcergo.com
For updated details of grievance officer, kindly refer the link:
https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	022 6234 6234 / 0120 6234 6234	NA	NA
Contact Point for Senior Citizen	022 6234 6234 / 0120 6234 6234	NA	NA
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West). MUMBAI – 400078.	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

i. If **Insured Person** is not satisfied with the redressal of grievance through above methods**,** the **Insured Person** may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

2. Specific General Terms

1. Geography

This Policy only covers Medical Treatment taken within India however Claims under Section B.1-2a) will be payable if diagnosis of the diseases is in;

- Canada
- Dubai
- Hong Kong
- Japan
- Malaysia
- New Zealand
- Singapore
- Switzerland
- USA
- European Union
- United Kingdom

2. 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 Schedule; and

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

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

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

b) Incorporate additional waiting period of not exceeding 3

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

d) 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 3 i above.

3. Grace Period

i. A grace period of 30 days for Renewals is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, any treatment availed for an Illness contracted during the grace period will not be admissible under the Policy.

ii. For **Renewal** received after completion of 30 days grace period, the policy would be considered as a fresh policy.

Section. 2 If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

i.

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

Installment Premium Option	Grace Period applicable
Half Yearly	30 days
Quarterly	30 days

Monthly	15 days

Section E – Others

1. Claims Procedure

On the occurrence of any Vetor Borne Diseases that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.

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 14 days of the diagnosis of Vector Borne Diseases
Particulars to be provided to Us for Claim notification	1. Policy Number, 2. Name of the Insured Person(s) named in the Policy schedule/Certificate of Insurance availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner/Hospital 5. Date and time of event if applicable 6. Date of admission
Claims documents for Vector Borne Diseases	1. Claim Form duly signed by the Insured Person; 2. Copy of Discharge Summary / Discharge Certificate; 3. First consultation letter from treating Medical Practitioner 4. Medical certificate confirming diagnosis, and the treatment of Vector Borne Diseases from Medical Practitioner 5. Certificate from treating Medical Practitioner, specifying the duration and etiology 6. All pathological Investigation Report. 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 a medical examination will be borne by Us. 7. NEFT details & cancelled cheque 8. All original medicine / pharmacy bills along with prescription by Medical Practitioner
Claims documents for Outpatient Treatment due to Vector Borne Diseases	All original consultation/diagnostic/pharmacy bills along with prescription by Medical Practitioner
Conditions for obtaining Cashless facility for Vector Borne Diseases	1. Cashless facility can be availed only at Our Network Provider. The complete list of Network Providers and Empaneled Service Providers is available on Our website and can be obtained by contacting Us. 2. 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. 3. 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.

	4. We will make payment for the Cashless authorized amount directly to the Network Provider 5. Applicable for Section B.1-2 – In case the hospital bill amount is lower than the payable benefit, We will directly pay You the difference between the benefit payable and the hospital bill amount. However, if the hospital bill amount is higher than the payable benefit, You will be require to settle the balance hospital bill on Your own. Conditions for Health Care at Home On receipt of duly filled pre authorization form with other sufficient details to assess the request, We will inform our Home Healthcare service provider who will follow the following process: i. Meet the treating medical practitioner and verify the requirement along with the prescription/discharge summary (if applicable) and the condition of the patient ii. Verify the past medical history of the patient iii. Complete physical examination of the patient iv. Check if the patient requires any equipment, devices etc v. Share the care plan and treatment cost estimation with Us. On receipt of the complete documents We may; i. issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable OR ii. reject the request for pre-authorization specifying reasons for the rejection. On rejection of Pre-Authorization under Home Healthcare, Claim procedure under Cashless treatment or Reimbursement may be followed.
Claims documents submission	In case of any Claim for the Insured Events, the list of documents as mentioned above shall be provided by the Policy Holder/ Insured Person, immediately but not later than 30 days of date of occurrence of an Insured Event, at own expense to avail the Claim
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. Contact Us

	within India	**Outside India**

Claim Intimation:	**Service No.** 022-62346234 / 0120-62346234 **Email**:healthclaims@hdfcergo.com	**Global Contact No** : +800 08250825 (accessible from locations outside India only) **Landline no (Chargeable)** : 0120-4507250 **Email:** travelclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, AndheriKurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

3. List of Ombudsman

S.No	Office Details	Jurisdiction of Office (Union Territory,District)
1	**AHMEDABAD** Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
2	**BENGALURU** Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.

3	**BHOPAL** Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202: Email : bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
4	**BHUBANESWAR** Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
5	**CHANDIGARH** Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
6	**CHENNAI** Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
7	**DELHI** Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

8	**GUWAHATI** Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Shri N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
10	**JAIPUR** Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
11	**KOCHI** Shri G. Radhakrishnan Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
12	**KOLKATA** Ms Kiran Sahdev Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.

13	**LUCKNOW** Shri. Atul Sahai Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	**MUMBAI** Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
15	**NOIDA** Shri Bimbadhar Pradhan Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
16	**PATNA** Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.

17	**PUNE** Shri Sunil Jain Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas 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

ListII–ItemsthataretobesubsumedintoRoomCharges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS

8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

ListIII–ItemsthataretobesubsumedintoProcedureCharges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE

9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

ListIV–Itemsthataretobesubsumedintocostsoftreatment

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