HDFC ERGO General Insurance Company Limited
Prospectus

Easy Health, Policy

Suitability:

a) This policy covers persons in the age group 91 days to 65 years. The maximum entry age is restricted upto 65 years. The Minimum entry age for Adult Dependent: is 18 years and Maximum entry age is 65 years

b) Child between 91 days and 5 years can be insured provided either parent is getting insured under this Policy.

c) There is no maximum cover ceasing age on renewals of the subject policy.

d) The policy will be issued for a period for 1 or 2 year(s) period, the sum insured & benefits will applicable on Policy Year basis.

e) This policy can be issued to an individual and/or family.

f) The family includes spouse, dependent children, dependent parents, parent-in-law, grandparents and grandchildren.

g) A maximum of 6 members can be added in a single policy, whether on an Individual or Family floater basis.

h) In a family floater policy, a maximum of 2 adults and a maximum of 5 children can be included in a single policy. The 2 adults can be a combination of Self, Spouse, Father, Father-in-law, Mother or Mother- in-law.

i) In an individual policy, a maximum of 4 adults and a maximum of 5 children can be included in a single policy. The 4 adults can be a combination of Self, Spouse, Father, Father-in-law, Mother or Mother- in-law.

j) The policy offers option of covering on individual sum insured basis – Easy Health Individual Health Insurance Plan and on family floater basis – Easy Health Family Floater Insurance Plan.

k) In an individual policy, the Sum Insured of the dependent insured members should be equal to or less than the Sum Insured of the Primary Insured member. In case where two or more children are covered, the Sum Insured for all the children must be same. Sum insured of all Dependent Parents and Dependent Parent in law must be same.

Note:

Dependents means only the family members listed below:

- Your legally married spouse as long as she continues to be married to You;
- Your children/ Grandchildren Aged between 91 days and 25 years if they are unmarried and financially dependent with no independent source of income. Children Aged between 1 to 90 Days can be covered if Newborn Baby Benefit is added by payment of additional premium subject to policy terms and conditions.
- Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Easy Health Policy,
- Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Easy Health Policy
- Your Grandparents provided that the grandparent were below 65 years at his initial participation in the Easy Health Policy,

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

Basic Sum Insured: The sum insured would Range from Rs. 1 Lac to Rs. 50 Lacs

Critical Illness Sum Insured would be 50% or 100% of the Sum Insured subject to a minimum of Rs 1 Lac and maximum of Rs 10 Lacs.

Salient Features & Benefits:

Section I. Inpatient Benefits

The following benefits are available to all Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or treatment defined as a Day Care Procedure or treatment defined as Domiciliary Treatment. Any claims made under these benefits will impact eligibility for Cumulative Bonus, and Health Checkup. For benefit limits, please refer to the schedule of benefit.

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

	d. Day Care Procedures Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours. Treatment normally taken on out-patient basis is not included in the scope of this definition.	1. Treatment that can be and is usually taken on an Out-Patient basis is not covered. 2. Treatment NOT taken at a Hospital
	e. Domiciliary Treatment Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: 1. The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or, 2. The Patient takes treatment at home on account of non availability of room in a Hospital. Pre and Post Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation and 90 days after hospitalization respectively will be covered in case of domiciliary treatment.	1. Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable only if treatment period is greater than 3 days)
	f. Organ Donor: Medical and surgical expenses of the organ donor for harvesting the organ where an Insured Person is the recipient Important: Expenses incurred by an insured person while donating an organ is NOT covered.	1. Claims which have NOT been admitted under Inpatient Treatment benefit for insured person 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
	g. Ambulance Cover: Expenses incurred on transportation of Insured Person to a hospital for treatment in case of an emergency, subject to Rs. 2000 per Hospitalisation..	1. Claims which have NOT been admitted under Inpatient Treatment benefit and Day care Procedure benefit 2. Healthcare or ambulance service provider not registered with road traffic authority.
	h. Ayush Benefit Expenses incurred on treatment taken under Ayurveda, Unani, Sidha and Homeopathy in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health subject to amounts specified in the Schedule of Benefits	1. Claims which have NOT been admitted under In-patient treatment 2. Hospitalisation for evaluation, Investigation only 3. Treatment availed outside India 4. Treatment at a healthcare facility which is NOT a Hospital.
	i. Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as mentioned in schedule of Benefits if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.	1. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 2. Claims which have NOT been admitted under Inpatient Treatment Benefit.

Section II. Additional Benefits: The following benefits are available to all Insured Persons during the Policy Period. Any claims made under these benefits will be subject to In-patient Sum Insured and will impact eligibility for a Cumulative Bonus and Health Checkup These benefits are applicable based on the plan variant selected, as mentioned in the schedule of benefits.		
2	a. Daily Cash for Accompanying an Insured Child*# If the Insured Person Hospitalised is a child Aged 12 years or less, daily cash amount will be payable as mentioned in schedule of Benefits for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours.	1. Daily Cash Benefit for days of admission and discharge Claims which have NOT been admitted under Inpatient Treatment Benefit.
	b. Newborn baby *# Medical Expenses for any medically necessary treatment described at Inpatient Treatment Benefit while the Insured Person (the Newborn baby) is Hospitalised during the Policy Period as an inpatient provided a proposal form is submitted for the insurance of the newborn baby within 90 days after the birth, and We have accepted the same and received the premium sought. Under this benefit, Coverage for newborn baby will incept from the date, the premium has been received. The coverage is subject to the policy exclusions, terms and conditions. This Benefit is applicable if Maternity benefit is opted and We have accepted a maternity claim under this Policy.	1. Claims which have NOT been admitted under Maternity Expenses Benefit 2. Claims other than those available in Inpatient Treatment Benefit.
	c. Recovery Benefit*# Lumpsum amount will be payable as mentioned in schedule of Benefits if the Insured Person is Hospitalised as an inpatient beyond 10 consecutive and continuous days This benefit is payable only once per Illness/Accident per Policy Year.	1. Claims which have NOT been admitted under Inpatient Treatment Benefit.
	d. Emergency Air Ambulance Cover We will pay for ambulance transportation in an airplane or helicopter subject to maximum limit prescribed in d(i) , for emergency life threatening health conditions which require immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide subject to: • Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency; • The Medical Evacuation been prescribed by a Medical Practitioner and is Medically Necessary; • The insured person is in India and the treatment is required in India only and not overseas in any condition whatsoever; and • The air ambulance provider being registered in India. d(i)The amount payable in case of Air ambulance facility shall be either the actual expenses or Rs. 2.5 Lacs per hospitalization, whichever is lower; upto basic sum insured limit for a year	1. Claims which have NOT been admitted under Inpatient Treatment or Day Care Procedures. 2. Expenses incurred in return transportation to the insured's home by air ambulance is excluded.

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Section III. Additional Benefit not related to Sum Insured: The following benefit is available to all Insured Persons during the Policy Period. Any claims made under these benefits will not be subject to In-patient Sum Insured and will not impact eligibility for a Cumulative Bonus and Health Checkup. These benefits are applicable based on the plan variant selected, as mentioned in the schedule of benefits.		
3	a. Maternity Expenses*# i. Medical Expenses for a delivery (including caesarean section) as mentioned in schedule of Benefits while Hospitalised or the lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person ii. Medical Expenses for pre-natal and post-natal expenses per delivery or termination upto the amount stated in the Schedule of Benefits, iii. Medical Expenses incurred for the medically necessary treatment of the new born baby upto the amount stated in the Schedule of Benefits unless the new born baby is covered under Newborn baby benefit, and iv. The Insured Person must have been an Insured Person under Our Policy for the period of time specified in the Schedule of Benefits.	1. Pre- and post-hospitalisation expenses under Pre- hospitalisation and post-hospitalisation benefit. 2. Ectopic pregnancy under this benefit (although it shall be covered under Inpatient Treatment Benefit. 3. Claim for Dependents other than Insured Person's spouse under this Policy.
	b. Outpatient Dental Treatment# Reasonable charges upto 50% of any necessary dental treatment taken from a Network dentist by an Insured Person who has been covered under this policy benefit for the previous 3 consecutive Policy Years and has renewed the policy in the fourth year, subject to amount specified in the Schedule of Benefits. We will pay for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same	1. Any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.
	c. Spectacles, Contact Lenses, Hearing Aid# Reasonable charges upto 50% of actual cost for One pair of spectacles or contact lenses, or a hearing aid, excluding batteries every third year provided that: i. If the costs claimed are incurred as Outpatient Treatment expenses then these items must be prescribed by a Network EYE/ENT specialised Medical Practitioner, and ii. Under a Family Floater, Our liability shall be limited to either one pair of spectacles or hearing aid per family. Our maximum liability shall be limited to the amount specified in the Schedule of Benefits	
	d. E-Opinion in respect of a Critical Illness # We shall arrange and pay for a second opinion from Our panel of Medical Practitioners, if: -The Insured Person suffers a Critical Illness during the Policy Period; and -He requests an E-opinion; and • The Insured Person suffers a Critical Illness during the Policy Period; and • He requests an E-opinion; and The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner. "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke. Note: This benefit will be provided under "Premium" Variant even if Critical illness rider is not opted.	1. More than one claim for this benefit in a Policy Year. 2. More than one claim for the same Critical Illness. Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.

	Note: *# Benefits are covered under "Exclusive" and "Premium" Variant only # Benefits are covered under "Premium" Variant only	
Section IV. Critical Illness **Any claims made under this benefit will not be subject to In-patient Sum Insured and will not impact eligibility for a Cumulative Bonus and Health Checkup. This benefit is optional and effective only if mentioned in the Schedule.**		
4	a. Critical Illness We will pay the Critical Illness Sum Insured as a lump sum in addition to Our payment under Inpatient Treatment Benefit, provided that: i. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and ii. The Insured Person survives for at least 30 days following such diagnosis. iii. "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke. Note: Critical Illness Rider is always provided on an individual sum insured basis irrespective of whether policy is issued on a individual or floater sum inured basis.	1. The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under an Easy Health Policy. 2. The Insured Person has already made a claim for the same Critical Illness. 3. A claim for this benefit has already been made 3 times under this Policy or any other Easy Health policy issued by Us.

Renewal Incentives:

Cumulative Bonus:

- A 10% cumulative bonus will be applied on the Sum Insured for next policy year under the Policy after every CLAIM FREE Policy Year, provided that the Policy is renewed with Us and without a break. The maximum cumulative bonus shall not exceed 100% of the Sum Insured in any Policy Year.
- In relation to a Family Floater, the cumulative bonus so applied will only be available in respect of claims made by those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.
- If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the cumulative bonus by 10% of the Sum Insured in that following Policy Year. There will be no impact on the Inpatient Sum Insured, only the accrued cumulative bonus will be decreased.
- If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated the no claim bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the no claim bonus to be carried forward for credit in the Policy would be the least no claim bonus amongst all the Insured Persons.
- Portability/Migration benefit will be offered to the extent of sum of previous sum insured and accrued cumulative bonus (if opted for), Portability/ Migration benefit shall not apply to any other additional increased sum insured.
- In policies with a two year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.

Preventive Health Checkup

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

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.

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

Easy Health, Policy

Stay Active-

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

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

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

The discount grid would be as per the table below:

1 Year Policy

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

2 Year Policy

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

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

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

Illustration

Policy start date	**1st Jan 2016**			
Policy Tenure	**1 year**			
Time Interval				
	Risk start date or date of download of mobile application -90 days	91 days-180 days	181 days-270 days	271- 300 days
Average steps taken in the defined time period	8500	10000	5001	7500
Discount %applicable	1.25%	1.25%	0.5%	0.5%

Total discount applicable on renewal premium = 3.5%

Special terms and conditions:

Waiting Period

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

i) 30-day waiting period: Code – Excl03

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

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident or underlying cause is cancer(s).
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability/migration stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures: -

Sl No	Organ / Organ System	Illness/diagnosis (irrespective of treatments medical or surgical)	Surgeries/procedures (irrespective of any illness/diagnosis other than cancers)
a	Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Nasal concha resection • Surgery for Turbinate hypertrophy • Nasal polypectomy
b	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
c	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
d	Gastrointestinal	• Cholecystitis • Cholelithiasis • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus • Ulcer and erosion of stomach and duodenum • Gastro Esophageal Reflux Disorder (GERD) • All forms of cirrhosis (Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses • Rectal Prolapse	• Cholecystectomy • Surgery of hernia

e	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f	Eye	• Cataract • Retinal detachment • Glaucoma	Nil
g	Others	Nil	• Surgery of varicose veins and varicose ulcers
h	General (Applicable to all organ systems/organs/ disciplines whether or not described above)	• Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, skin tumors	• NIL

iii. Pre-Existing Diseases: Code – Excl01

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

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

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

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

General exclusions

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

Non Medical Exclusions

1) Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

2) Intentional self injury or attempted suicide while sane or insane.

3) 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.

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

Medical Exclusions

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

6) Prosthetic and other devices which are self-detachable/removable without surgery involving anaesthesia

7) Treatment availed outside India

8) Treatment at a healthcare facility that is not a Hospital

9) Obesity/ Weight Control: Code – Excl06
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   i. Surgery to be conducted is upon the advice of the Doctor
   ii. The surgery/Procedure conducted should be supported by clinical protocols
   iii. The member has to be 18 years of age or older and
   iv. Body Mass Index (BMI);
      a) greater than or equal to 40 or
      b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnoea
   iv. Uncontrolled Type2 Diabetes

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

11) 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.

12) Circumcisions (unless necessitated by Illness or injury and forming part of treatment)
13) 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.
14) Non allopathic treatment except to the extent provided for under 1h).
15) Conditions for which treatment could have been done on an outpatient basis without any Hospitalization
16) 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
17) Investigation & Evaluation: Code – Excl04
    a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
    b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
18) Rest Cure, rehabilitation and respite care: Code – Excl05
    a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
        i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
        ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
19) Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment)
20) Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips except to the extent provided in 3c).
21) Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code – Excl13
22) 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.
23) Sleep apnoea.
24) Congenital external diseases, defects or anomalies
25) Growth hormone therapy
26) Maternity(except to the extent provided for under 3a)): Code – Excl18
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
27) Sterility and Infertility: Code – Excl17
    Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization
28) Expenses incurred by the insured on organ donation
29) Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
30) Save as and to the extent provided for under 3) b), dental treatment and surgery of any kind, unless requiring Hospitalisation except to the extent provided for under 3b).
31) Any non medical expenses mentioned in Annexure I
32) 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.
33) Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.
34) Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.
35) Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.
36) Drugs or treatments which are not supported by a prescription.
37) Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured.
38) Admission for administration of Intra-articular or Intra-lesional injections, Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc.) or IV immunoglobulin infusion

Claim Procedure:

All claims under this policy will be processed and settled by HDFC ERGO General Insurance Company Limited. At network centers claims would be settled on cashless basis and on reimbursement basis in non network centers

a) Intimation & Assistance

Please contact HDFC ERGO General Insurance Company Limited at least 48 hrs prior to an event which might give rise to a claim. For any emergency situations, kindly contact HDFC ERGO General Insurance Company Limited within 24 hours of the event.

b) Procedure for Reimbursement of Medical Expenses

- HDFC ERGO General Insurance Company Limited must be informed no later than 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/documents mentioned therein to HDFC ERGO General Insurance Company Limited 15 days of the occurrence of the Incident. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured

* Please refer to claim form for complete documentation.

- If there is any deficiency in the documents/information submitted by you, HDFC ERGO General Insurance Company Limited will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents, HDFC ERGO General Insurance Company Limited will send admissible amount, along with a settlement statement within 30 days.
- The payment will be made in the name of the Policyholder.

c) Claim Procedure to avail Cashless facility -

- For any emergency Hospitalisation, HDFC ERGO General Insurance Company Limited must be informed no later than 24 hours after hospitalization.
- For any planned hospitalization, kindly seek cashless authorization from HDFC ERGO General Insurance Company Limited at least 48 hours prior to the hospitalization.
- HDFC ERGO General Insurance Company Limited will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents.
- Please pay the non-medical and expenses not covered to the hospital prior to the discharge.
- In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours.

Note:

Payment will only be made for items covered under your policy and upto the limits therein.

- Insured person is entitled for cashless coverage only in our empaneled hospitals.
- Please refer to the list of empaneled hospitals on our website or the list provided along with Policy kit or call us on our Customer care number at 022 6234 6234 / 0120 6234 6234.
- Rejection of cashless facility in no way indicates rejection of the claim.

Terms of Renewal:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.
- **Renewal** shall not be denied on the ground that the **Insured Person** had made a claim or claims in the preceding policy years.
- Request for **Renewal** along with requisite premium shall be received by the Company before the end of the policy period.
- At the end of the policy period, the **Policy** shall terminate and can be renewed within the **Grace Period** of 30 days to maintain continuity of benefits without **Break in Policy**. Coverage is not available during the **Grace Period**.
- No loading shall apply on renewals based on individual claims experience.
- **Sum Insured Enhancement** – Sum Insured can be enhanced only at the time of renewal subject to no claim have been lodged/ paid under the policy. If the insured increases the sum insured one grid up, no fresh medicals shall be required. In cases where the sum insured increase is more than one grid up, the case shall be subject to medicals. In case of increase in the Sum Insured waiting period will apply afresh in relation to the amount by which the Sum Insured has been enhanced. However the quantum of increase shall be at the discretion of the company.
- Any Insured Person in the policy has the option to migrate to similar indemnity health insurance policy available with us at the time of renewal subject to underwriting with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break.

Pre- Acceptance Medical Test:

- Pre-Policy Checkup at our network may be required based upon the age and Sum Insured. We will reimburse 100% of the expenses incurred per insured person on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

Discounts

1) Family Discount of 5% if 2 members are covered and 10% if 3 or more family members are covered under Easy Health Individual Health Insurance Plan
2) 7.5% Discount on premium if Insured Person is paying premium of 2 years in advance as a single premium.

Examples

a. Proposed Insured Age 33 years opting for Easy Health Individual Standard 2 year policy with Sum Insured of Rs 2 Lac.
Calculation – 3213X 2 X 92.5% = Rs. 5944.05/- plus taxes.

b. Proposed Insured Age 35 years opting for Easy Health Individual Standard 2 year policy with Sum Insured of Rs 2 Lac.
Calculation – (3213+3636) X 92.5% = Rs. 6335..32/- plus taxes.Example for Family discount and 2 year advance premium discount
Proposed Insured aged 32 years opting for a 2 year Standard individual policy covering himself ,spouse and child for a sum insured of 5 Lacs each

Premium calculation

Insured person	Age	Sum Insured	Premium (ex tax)
Self	32	5 Lacs	6117
Spouse	31	5 Lacs	6117

Child	6	5 Lacs	5120
Total premium (ex tax)			17354
2 year discount of 7.5%			1302
Premium after 2 year discount			16052
10% family discount			1605
Total premium payable (ex tax)			14447

Termination (Other than Free Look period)

- 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.

1 Year Policy Period		2 Year Policy Period	
Length of time Policy in force	Refund of premium	Length of time Policy in force	Refund of premium
Upto 1 Month	75.00%	Upto 1 Month	87.50%
Upto 3 Months	50.00%	Upto 3 Months	75.00%
Upto 6 Months	25.00%	Upto 6 Months	62.50%
Exceeding 6 Months	Nil	Upto 12 Months	48.00%
		Upto 15 Months	25.00%
		Upto 18 Months	12.00%
		Exceeding 18 Months	Nil

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**.

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

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

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 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 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.

Non-disclosure or Misrepresentation

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

- cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion,

upon 15 day notice by sending an endorsement to Your address shown in the Schedule; and

- the claim under such Policy if any, shall be rejected/repudiated forthwith.

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

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

b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

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

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

Dishonest or Fraudulent Claim

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

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

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent or the hospital/ doctor/any other party acting on behalf of the **Insured Person**, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

c) any other act fitted to deceive; and

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

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

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.

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.

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.

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.

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.

Nomination:

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

Payment Facility:

- Online
- Cheque/ Cash/ Credit Card Payment
- Electronic Clearing System

Renewability:

- There shall be no cover ceasing age on renewal.

Tax Benefit:

- The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

Requirement:

- Completed proposal form

Easy Health, Policy

This Policy is subject to regulation 12 of IRDAI (Protection of Policyholder's Interests) Regulations 2017.
Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDA.

Disclaimer:

This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification.

Schedule of Benefits - Easy Health Individual

	Standard	Exclusive			Premium		
Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	1.00, 1.50, 2.00, 2.50, 3.00, 4.00, 5.00, 7.50, 10.00, 15.00	3.00, 4.00, 5.00	7.50,10.00	15.00, 20.00, 25.00, 50.00	3.00, 4.00, 5.00	7.50, 10.00	15.00, 20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered	Covered			Covered		
1 b) Pre - hospitalisation	Covered	Covered			Covered		
1 c) Post-hospitalisation	Covered	Covered			Covered		
1 d) Day Care Procedures	Covered	Covered			Covered		
1 e) Domiciliary Treatment	Covered	Covered			Covered		
1 f) Organ Donor	Covered	Covered			Covered		
1 g) Emergency Ambulance	Upto Rs. 2000 per hospitalisation	Upto Rs. 2000 per hospitalisation			Upto Rs. 2000 per hospitalisation		
1 h) Ayush Benefit	Upto Rs. 20,000	Upto Rs. 25,000		Upto Rs. 50,000	Upto Rs. 25,000		Upto Rs. 50,000
1 i) Daily Cash for choosing Shared Accommodation	Rs.500 per day, Maximum Rs.3,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
2 a) Daily Cash for accompanying an insured child	Not Covered	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.800 per day, Maximum Rs.24,000	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.800 per day, Maximum Rs.24,000
2 b) Newborn baby	Not Covered	Additional Benefit on payment of additional premium			Additional Benefit on payment of additional premium		
2 c) Recovery Benefit	Not Covered	Not Covered		Rs. 10,000	Not Covered		Rs. 10,000
2 d) Emergency Air Ambulance	Not Covered	Not Covered		Upto Rs.2.5 Lacs per hospitalisation	Not Covered		Upto Rs.2.5 Lacs per hospitalisation
3 a) Maternity Expenses	Not Covered	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (* Including Pre/Post Natal limit of Rs.1,500 and New Born limit of Rs.2,000) [Waiting Period of 6 years]	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (* Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500) [Waiting Period of 6 years]	Normal Delivery Rs. 30,000* Caesarean Delivery Rs. 50,000* (* Including Pre/ Post Natal limit of Rs. 5,000 and New Born limit of Rs.5,000) [Waiting Period of 4 Years]	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (* Including Pre/ Post Natal limit of Rs.1,500 and New Born limit of Rs.2,000) [Waiting Period of 6 years]	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (* Including Pre/ Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500) [Waiting Period of 6 years]	Normal Delivery Rs. 30,000* Caesarean Delivery Rs. 50,000* (* Including Pre/ Post Natal limit of Rs. 5,000 and New Born limit of Rs.5,000) [Waiting Period of 4 Years]
3 b) Outpatient Dental Treatment Waiting Period 3 years	Not Covered	Not Covered			Upto 1 % of Sum insured subject to a Maximum of Rs. 5,000		Upto 1 % of Sum insured subject to a Maximum of Rs. 7,500

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3 c) Spectacles, Contact Lenses, Hearing Aid Every Third Year	Not Covered	Not Covered		Upto Rs. 5,000	Upto Rs. 7500
3 d) E-Opinion in respect of a Critical Illness	Not Covered	Not Covered		Covered	
4 Critical Illness Rider	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured subject to minimum of Rs 100,000 upto a maximum of Rs. 10 Lacs	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured upto a maximum of Rs 10 Lacs	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured upto a maximum of Rs 10 Lacs
5 Health Checkup	Upto 1% of Sum Insured per Insured Person upto Rs.5000, only once at the end of a block of every continuous four claim free years.	Upto 1% of Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous three policy years		Upto 1% of Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous two policy years	
Benefits under 3b), 3c), 3d) and 5) are subject to pre-authorisation by the HDFC ERGO General Insurance Company Limited					

Schedule of Benefits - Easy Health Individual

	Standard	Exclusive			Premium		
Sum Insured per Policy per Policy Year (Rs. in Lakh)	2.00, 3.00, 4.00, 5.00, 7.50, 10.00, 15.00	3.00, 4.00, 5.00	7.50,10.00	15.00,20.00, 25.00, 50.00	4.00, 5.00	7.50, 10.00	15.00,20.00, 25.00, 50.00
1 a) In-patient Treatment	Covered	Covered			Covered		
1 b) Pre -hospitalisation	Covered	Covered			Covered		
1 c) Post -hospitalisation	Covered	Covered			Covered		
1 d) Day Care Procedures	Covered	Covered			Covered		
1 e) Domiciliary Treatment	Covered	Covered			Covered		
1 f) Organ Donor	Covered	Covered			Covered		
1 g) Emergency Ambulance	Upto Rs.2000 per hospitalisation	Upto Rs.2000 per hospitalisation			Upto Rs.2000 per hospitalisation		
1 h) Ayush Benefit	Upto Rs 20,000	Upto Rs 25,000		Upto Rs 50,000	Upto Rs 25,000		Upto Rs 50,000
1 i) Daily Cash for choosing Shared Accommodation	Rs.500 per day, Maximum Rs.3,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
2 a) Daily Cash for accompanying an insured child	Not Covered	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.800 per day, Maximum Rs.24,000	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.800 per day, Maximum Rs.24,000
2 b) Newborn baby	Not Covered	Additional Benefit on payment of additional premium			Additional Benefit on payment of additional premium		
2 c) Recovery Benefit	Not Covered	Not Covered		Rs 10,000	Not Covered		Rs 10,000
2 d) Emergency Air Ambulance	Not Covered	Not Covered		Upto Rs.2.5 Lacs per hospitalisation	Not Covered		Upto Rs.2.5 Lacs per hospitalisation

3 a) Maternity Expenses	Not Covered	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (*Including Pre/ Post Natal limit of Rs.1,500 and New Born limit of Rs.2,000) [Waiting Period 4 years]	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (*Including Pre/ Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500) [Waiting Period 4 years]	Normal Delivery Rs. 30,000* Caesarean Delivery Rs. 50,000* (*Including Pre/Post Natal limit of Rs. 5,000 and New Born limit of Rs.5,000) [Waiting Period of 3 Years]	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (*Including Pre/Post Natal limit of Rs.1,500 and New Born limit of Rs.2,000) [Waiting Period 4 years]	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (*Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500) [Waiting Period 4 years]	Normal Delivery Rs. 30,000* Caesarean Delivery Rs. 50,000* (*Including Pre/Post Natal limit of Rs. 5,000 and New Born limit of Rs.5,000) [Waiting Period of 3 Years]
3 b) Outpatient Dental Treatment Waiting Period 3 years	Not Covered	Not Covered			Upto 1 % of Sum insured subject to a Maximum of Rs.5,000		Upto 1 % of Sum insured subject to a Maximum of Rs. 10,000
3 c) Spectacles, Contact Lenses, Hearing Aid Every Third Year	Not Covered	Not Covered			Upto Rs.5,000		Upto Rs. 10,000
3 d) E-Opinion in respect of a Critical Illness	Not Covered	Not Covered			Covered		
4 Critical Illness Rider	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured subject to minimum of Rs 100,000 upto a maximum of Rs. 10 Lacs	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured		Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured upto a maximum of Rs 10 Lacs	Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured		Optional, if opted then the Critical Illness Sum Insured 50% or 100% of In-patient Sum Insured upto a maximum of Rs 10 Lacs
5 Health Checkup	Upto 1% of Sum Insured per Policy upto Rs.5000, only once at the end of a block of every continuous four claim free years	Upto 1% of Sum Insured per Policy subject to a Maximum of Rs. 5,000 per Insured Person, only once at the end of a block of every continuous three policy years.			Upto 1% of Sum Insured per Policy subject to a Maximum of Rs. 5,000 per Insured Person, only once at the end of a block of every continuous two policy years.		
Benefits under 3b), 3c), 3d) and 5) are subject to pre-authorisation by the HDFC ERGO General Insurance Company Limited							

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