Easy Health
Policy Wording

HDFC ERGO Health Insurance Ltd. will cover all Insured Persons under this Policy upto the Sum Insured. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

Section I. Inpatient Benefits

This section of benefits is applicable when

- An insured suffers an Accident or Illness, which is covered under this Policy
- Hospitalisation is necessary & is done for treatment OR
- Day care treatment is necessary and is done OR
- Domiciliary treatment is necessary and is done

IMPORTANT: Any claims made under these benefits will impact eligibility for Cumulative Bonus, and Health Checkup.

We will cover the Medical Expenses for:		We will not cover treatment, costs or expenses for*: *The following exclusions apply in addition to the waiting periods and general exclusions specified in section VI A and VI C. In addition to the waiting periods (Section 6a) and general exclusions (Section 6c), 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) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	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 Hospital (Inpatient or Day Care or Domiciliary treatment)	1. Claims which have NOT been admitted under 1a), 1d) & 1e) 2. Expenses not related to the admission and not incidental to the treatment for which the admission has taken place
	c. Post-Hospitalization expenses for consultations, investigations and medicines incurred upto 90 days after discharge from Hospitalisation (Inpatient or Day Care or Domiciliary treatment).	1. Claims which have NOT been admitted under 1a), 1d) & 1e) 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. Indicative list of Day Care Procedures • Cancer Chemotherapy • Liver biopsy • Coronary angiography • Haemodialysis • Operation of cataract • Nasal sinus aspiration	i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) 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 only if treatment period is greater than 3 days).

Important terms You should know

Sum Insured means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Day Care Procedures means those medical treatment, and/or surgical procedure listed in Annexure 1
i) Which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement,
ii) Which would have otherwise required a Hospitalisation of more than 24 hours treatment normally taken on an Out-patient basis is not included in the scope of this definition. .

Outpatient Treatment is 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 daycare or inpatient.

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 licence. And is NOT a member of the Insured Person's family or stays with him.

Shared accommodation means a Hospital room with two or more patient beds.

Single occupancy or any higher accommodation and type means a Hospital room with only one patient bed.

Please retain your policy wording for current and future use. Any change to the policy wording at the time of renewal, post approval from regulator will be updated and available on our website www.hdfcergohealth.com

	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 1a) for insured member. 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 a 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 Section 1a) and Section 1d). 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 1a) 2. Hospitalisation for evaluation, Investigation only 3. Treatment availed outside India 3. 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 1a).
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 2. Claims which have NOT been admitted under 1a).
	b. Newborn Baby Medical Expenses for any medically necessary treatment described at 1)a) 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 3a) i.e. Maternity Expenses 2. Claims other than those available in Section 1, Section VI A, Section VI C
	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 1a).

Newborn Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

Maternity Expense shall include -

(a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

(b) expenses towards lawful medical termination of pregnancy during the policy period.

	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.
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 2b), 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 1)b) and 1)c) 2. Ectopic pregnancy under this benefit (although it shall be covered under 1a) 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 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.
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 1)a), 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 an 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.

Section V Renewal Benefits:

Cumulative Bonus

a) 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.

b) 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.

c) 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..

d) 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.

e) 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.

f) In policies with a two year Policy Period, the application of above guidelines of Cumulative Bonus shall be post completion of each policy year.

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	Maximum Discount 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%

Preventive Health Check-up

a) If You have maintained an Easy Health Policy with Us for the period of time mentioned in the Schedule of Benefits without any break, then at the end of each block of continuous years (as mentioned in the Schedule of benefits) We will pay upto the percentage (mentioned in the Schedule of Benefits) of the Sum Insured for this Policy Year or the subsequent Policy Years (whichever is lower) towards the cost of a preventive health check-up for those Insured Persons who were insured for the number of previous Policy Years mentioned in the Schedule.

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.

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

b) In case of family floater in Standard Variant, if any of the members have made a claim under this Policy, the health check-up benefit will not be offered to the whole family.

c) We will consider complete policy years for the eligibility of this benefit.

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.

Section VI. Special terms and conditions

A. Waiting Period

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

i) 30-day waiting period: 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: 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	(irrespective of treatments medical or surgical)	Surgeries/ procedure (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 • Nasal polypectomy • Surgery for Turbinate hypertrophy
b	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease • Fibroids (fibromyoma)	• Hysterectomy
c	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis	• Surgery for prolapsed inter vertebral disk • Joint replacement surgeries
d	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • 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	• Cholecystectomy • Surgery of hernia
e	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f	Eye	• Cataract	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)	• Internal tumours, cysts, nodules, polyps, skin tumours	• NIL

However, a waiting period of 90 days only be applicable after the date of inception of the first policy if above surgeries/ procedures need to be performed if caused by Hypertension, Diabetes or Cardiac conditions, except if these diseases are pre-existing and disclosed at the time of underwriting.

iii) Pre-Existing Diseases: 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.

PI Note: Coverage under the policy for any past illness/condition or surgery is subject to the same being declared at the time of application and accepted by Us without any exclusion.

B. Reduction in waiting periods

1) If the proposed Insured Person is presently covered and has been continuously covered without any lapses under:

(a) Any health insurance plan with an Indian non life insurer as per guidelines on portability/migration, OR

(b) Any other similar health insurance plan from Us,

Then:

(a) The waiting periods specified in Section VI A i), ii) and iii) of the Policy stand deleted; AND:

(b) The waiting periods specified in the Section VI A i), ii) and iii) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy; AND

(c) If the proposed Sum Insured for a proposed Insured Person is more than the Sum Insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the Sum Insured and any other accrued sum insured under the previous health insurance policy.

2) The reduction in the waiting period specified above shall be applied subject to the following:

a) We will only apply the reduction of the waiting period if We have received the database and claim history from the previous Indian insurance company (if applicable);

b) We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation and information.

c) We will retain the right to underwrite the proposal.

d) We shall consider only completed years of coverage for waiver of waiting periods. Policy Extensions if any sought during or for the purpose of porting insurance policy shall not be considered for waiting period waiver.

C. General exclusions

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

Non Medical Exclusions

1. War or similar situations:

   Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (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: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent: Excl10
4. Hazardous or Adventure sports: 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. : 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: 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. Refractive Error: Excl15

    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
11. Cosmetic or plastic Surgery: 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 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: 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
17. Investigation & Evaluation: 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: 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. : 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. Excl14
23. Sleep apnoea; External congenital diseases, defects or anomalies.
24. Growth hormone therapy.
25. Venereal disease, sexually transmitted disease or illness;
26. Maternity(except to the extent provided for under 3a)): 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: 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. 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: 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

Section VII. General Conditions

a. Conditions to be followed

The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability. The premium for the policy will remain the same for the policy period as mentioned in policy schedule. .

b. Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India.

The premium will be computed basis the city of residence provided by the insured person in the application form. The premium that would be applicable zone wise and the cities defined in each zone are as under:

- Delhi NCR/Mumbai MMR- Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida ,Mumbai, Navi Mumbai , Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai,Virar
- Rest of India- All other cities

The premium will be modified in case of mid -term address change involving migration from one zone to another and would be calculated on pro-rata basis.

c. Insured Person

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

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 as per portability/migration guidelines.

If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will return a rateable part of the premium received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

d. Loadings & Discounts

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after getting Your consent and additional premium (if any). Please visit our nearest branch to refer our underwriting guidelines if required.

We will provide a Family Discount of 5% if 2 members are covered and 10% if 3 or more family members are covered under a single Easy Health Individual Health Insurance Plan. An additional discount of 7.5% will be provided if insured person is paying two year premium, in advance as a single premium. These discounts shall be applicable at inception and renewal of the policy

e. Notification of Claim

	Treatment, Consultation or Procedure:	We must be notified:
i)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency:	Within 24 hours of the start of the Insured Person's Hospitalisation.
iii)	For all benefits which are contingent on Our prior acceptance of a claim under Section 1)a):	Within 7 days of the Insured Person's discharge post-hospitalisation.

f. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars.
i)	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or hospitalisation.
ii)	If Any treatment, consultation or procedure for which a claim may be made taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation.

g. Supporting Documentation & Examination

The Insured Person or someone claiming on your behalf shall provide Us with any documentation, medical records and information We A may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. 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. Such documentation will include but is not limited to the following::

i) Our claim form, duly completed and signed for on behalf of the Insured Person.

ii) Original bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

iii) All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries

iv) A precise diagnosis of the treatment for which a claim is made.

v) A detailed list of the individual medical services and treatments provided and a unit price for each.

vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice

vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made

viii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection

ix) Treating doctors certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident

x) Copy of settlement letter from other insurance company or TPA

xi) Stickers and invoice of implants used during surgery

xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident

xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

xiv) Legal heir certificate

h. The Insured Person will have to undergo medical examination by Our authorised Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the ice: cost towards performing such medical examination (at the specified location) of the Insured Person.

i. Claims Payment

i) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii) We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).

iii) The assignment of benefits of the policy shall be subject to applicable law.

iv) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an emergency.

v) We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of receipt of last necessary document(s) / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document(s) to the date of payment of claim. For the purpose of this clause, 'bank rate' shall mean the bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

vi) Where the circumstances of a claim warrant an investigation in our Opinion, We 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, We shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days , We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

vii) Healthcare Advisory Benefit: We may suggest alternate Network Provider in specific cases of surgical or medical treatment, should the Insured member accept and utilize one of the alternatives suggested he would be eligible for a lump sum benefit of Rs 5000.

Please note: The acceptance of our recommendation is not obligatory on the Insured member and We are not liable for any outcome of the treatment conducted at the network centre.

j. 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 30 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.

k. Dishonest or Fraudulent Claims:

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or the Insured Person or anyone acting on behalf of You or an Insured Person, then this 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 30 day notice by sending an endorsement to Your address shown in the Schedule and
- All benefits Payable, if any, under such Policy shall be forfeited with respect to such claim.

l. Other Insurance

If at the time when any claim is made under this Policy, insured has two or more policies from one or more Insurers to indemnify treatment cost, which also covers any claim (in part or in whole) being made under this Policy, then the Policy holder shall have the right to require a settlement of his claim in terms of any of his policies. The insurer so chosen by the Policy holder shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen policy.
Provided further that, If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies

m. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and

stamped by Us.

n. Renewal

This Policy is ordinarily renewable for life unless the Insured Person or anyone acting on behalf of an Insured Person has acted in a dishonest or fraudulent manner or there has been any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

i) We are NOT under any obligation to:

- Send renewal notice or reminders.
- Renew it on same terms or premium as the expiring Policy. Any change in benefits or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to You at least 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy. You will have the option to migrate to similar indemnity health insurance policy available with us at the time of renewal with all continuity benefit of waiver of waiting period provided the policy has been maintained without a break as per portability/migration guidelines.

ii) We will not apply any additional loading on your policy premium at renewal based on claim experience.

iii) 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.

iv) We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.

v) All applications for renewal of the Policy must be received by Us before the end of the Policy Period. A Grace Period of 30 days for renewing the Policy is available under this Policy. Any disease/ condition contracted during the Grace Period will not be covered and will be treated as a Pre-existing Condition.

o. Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

p. Notices

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement

ii) Us, shall be delivered to Our address specified in the Schedule.

iii) No insurance agents, brokers or other person/ entity is authorised to receive any notice on Our behalf.

q. Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

r. Termination

i) You may terminate this Policy at any time by giving Us written notice. The cancellation shall be from the date of receipt of such written notice. Premium shall be refunded as per table below IF AND ONLY IF no claim has been made under the Policy

1 Year Policy		2 Year Policy	
Length of time Policy in force	% of premium refunded	Length of time Policy in force	% of premium refunded
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

ii) We shall terminate this Policy for the reasons as specified under aforesaid section VII j) (Non Disclosure or Misrepresentation) & section VII k) (Dishonest or Fraudulent Claims) of this Policy and such termination of the Policy shall be ab initio from the inception date or the renewal date (as the case may be), upon 30 day notice, by sending an endorsement to Your address shown in the Schedule

s. Free Look Period

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel Your Policy only if You have not made any claims under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of renewal of the Policy.

Section VIII. Other Important Terms You should know

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

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

Def.2. Age or Aged means completed years as at the Commencement Date.

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

Def.4. Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/ Nursing Home where treatment may have been taken.

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 approved.

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

Def.7. Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def.8. Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position

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

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

Def.9. Contribution means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def.10. 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 claim amount. A co-payment does not reduce

the Sum Insured.

Def.11. Cumulative Bonus means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def.12. Critical Illness means Cancer of specified severity, Open Chest CABG, First Heart Attack of specified severity, Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs, Stroke resulting in Permanent Symptoms as defined below only:

i) Cancer of specified severity:

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection.

ii) Open Chest CABG:

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The Diagnosis must be supported by coronary angiography and realisation of the surgery has to be confirmed by a specialist Medical Practitioner

- The following are excluded:
- Angioplasty and / or Any other intra-arterial procedures
- Any Key-hole surgery or laser surgery

iii) First Heart Attack of Specified Severity:

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
- New characteristic electrocardiogram changes.
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.
- Other acute Coronary Syndromes.
- Any type of angina pectoris

iv) Kidney Failure requiring Regular Dialysis:

End stage renal disease presented as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out.

The diagnosis has to be confirmed by a specialist Medical Practitioner

v) Major Organ/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

- One of the following human organs - heart, lung, liver, pancreas, kidney, that resulted from irreversible end-stage failure of the relevant organ or;
- Human bone marrow using hematopoietic stem cells.

The undergoing of a transplant must be confirmed by specialist medical practitioner.

The following are excluded:

- Other Stem-cell transplants
- Where only islets of Langerhans are transplanted

vi) Multiple Sclerosis with Persisting Symptoms:

The definite occurrence of Multiple Sclerosis.The diagnosis must be supported by all of the following:

- Investigation including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple Sclerosis.
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least 1 month apart.

Excluded is:

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

vii) Permanent Paralysis of Limbs:

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist Medical Practitioner (Physician / Neurologist) must be of the opinion that paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

viii) Stroke resulting in Permanent Symptoms:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source.

The diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular diseases affecting only the eye or optic nerve or vestibular functions

Def.13. Day Care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- 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.14. Day Care Procedures means those medical treatment, and/or surgical procedure

i. which is undertaken under General or Local Anaesthesia in a Hospital/ day care centre in less than 24 hours because of technological advancement,

ii. which would have otherwise required a Hospitalisation of more than

24 hours.

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

Def.15. 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.16. Dental treatment a treatment related to teeth or structures supporting teeth including examinations, filings (where appropriate), crowns, extractions and surgery.

Def.17. Dependents means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;

ii) 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.

iii) 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,

iv) 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

v) 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.

Def.18. Dependent Child means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources 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.

Def.19. Domiciliary Hospitalisation means medical treatment for an illness/disease/ injury which in the normal course would require a care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- The patient takes treatment at home on account of non-availability of a room in a hospital

Def.20. 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.21. Emergency Care means management for a severe 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.22. Family Floater means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def.23. Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

Def.24. 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 qualified nursing staff under its employment round the clock,
- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- 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.25. Hospitalisation or Hospitalised means admission in a Hospital for a minimum 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.26. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

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

b) Chronic Condition- A chronic condition is defined as disease, illness, or injury that has one or more o f the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it recurs or is likely to recur

Def.27. 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.28. 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.29. Insured Person means You and the persons named in the Schedule.

Def.30. 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.31. ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the coverage for bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Def.32. Maternity expenses means

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections during hospitalization);

ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

Def.33. Medical Advise means any consultation or advise from a Medical Practitioner including the issuance of any prescription or follow up prescription.

Def.34. 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 doctors in the same locality would have charged for the same medical treatment.

Def.35. Medically Necessary 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.36. 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.

Def.37. Migration means the right accorded to individual health insurance policyholders (including all members under family cover and members of group health insurance policy) to transfer the credits gained for pre-existing conditions and time-bound exclusions, with the same insurer.

Def.38. Network Provider means Hospital enlisted by an insurer or a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility.

Def.39. New Born Baby means baby born during the Policy Period and is aged up to 90 days.

Def.40. Non Network Provider means any Hospital, day care centre or other provider that is not part of the Network

Def.41. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def.42. 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.43. Portability means the right accorded to individual health insurance policyholders (including all members under family cover) to transfer the credits gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

Def.44. Pre-existing Disease means any condition, ailment, injury or disease:

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

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

Def.45. Pre- Hospitalisation Medical Expenses means the medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

Def.46. Post- Hospitalisation Medical Expenses means medical expenses incurred during predefined 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.47. Policy means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure 1 and the Schedule (as the same may be amended from time to time).

Def.48. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def.49. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def.50. 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.51. Reasonable & Customary Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def.52. Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include associated medical expenses.

Def.53. 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.54. Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def.55. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

Def.56. Unproven/Experimental treatment means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def.57. We/Our/Us means the HDFC ERGO Health Insurance Limited.

Def.58. You/Your/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

Section IX. Claim Related Information

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

Website : www.hdfcergohealth.com

Email : customerservice@hdfcergohealth.com

Toll Free : 1800 - 102 - 0333

Fax : 1800 - 425 - 4077

Courier : Claims Department,
HDFC ERGO Health Insurance Ltd.,
Ground Floor, Srinilaya - Cyber Spazio,
Road No. 2, Banjara Hills, Hyderabad-500034, Telangana.

or : Claims Department,
HDFC ERGO Health Insurance Ltd.,
Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana.

Additional Note: Please refer to the list of empanelled network centers on our website or the list provided in the welcome kit.

Section X. Grievance Redressal Procedure

If you have a grievance that you wish us to redress, you may contact us with the details of Your grievance through:

Website : www.hdfcergohealth.com

Email : customerservice@hdfcergohealth.com

E-mail specific for Senior citizens : seniorcitizen@hdfcergohealth.com

Toll Free : 1800-102-0333

Fax : +91 124 4584111

Courier : Any of Our Branch office or corporate office

You may also approach the grievance cell at any of Our branches with the details of Your grievance during Our working hours from Monday to Friday.

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may contact Our Head of Customer Service at:

The Grievance Cell, HDFC ERGO Health Insurance Ltd., iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III, Gurgaon -122016, HARYANA

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may approach the nearest Insurance Ombudsman for resolution of

Your grievance. The contact details of Ombudsman offices are mentioned below.

Office of The Executive Council of Insurers (Monitoring Body for Offices of Insurance Ombudsman) 3rd Floor, Jeevan Seva Annexe, Santacruz(West), Mumbai – 400054. Tel no: 26106671/6889. Email id: inscoun@ecoi.co.in website: www.ecoi.co.in
If you have a grievance, approach the grievance cell of Insurance Company first. If complaint is not resolved/ not satisfied/not responded for 30 days then You can approach The Office of the Insurance Ombudsman (Bimalokpal). Please visit our website for details to lodge complaint with Ombudsman.

Office Details
Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, Ahmedabad - 380001. Tel nos: 079-25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, BHOPAL-462 003. Tel.:- 0755-2769201/9202 Fax : 0755-2769203 Email: bimalokpal.bhopal@ecoi.co.in
Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455/2596003 Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Office of the Insurance Ombudsman, SCO No.101-103,2nd Floor, Batra Building, Sector 17-D, CHANDIGARH-160 017. Tel.:- 0172-2706468/2772101 Fax : 0172-2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.:- 044-24333668 /24335284 Fax : 044-24333664 Email: bimalokpal.chennai@ecoi.co.in
Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-23234057/23232037 Fax : 011-23230858 Email: bimalokpal.delhi@ecoi.co.in
Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, S.S. Road, GUWAHATI-781 001 . Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: bimalokpal.guwahati@ecoi.co.in
Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel : 040-65504123/23312122 Fax: 040-23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759/2359338 Fax : 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in

Office Details
Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R.Avenue, KOLKATA - 700072 Tel No: 033-22124339/22124346 Fax: 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331/2231330 Fax : 0522-2231310 Email: bimalokpal.lucknow@ecoi.co.in
Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,S.V. Road, Santacruz (W), MUMBAI - 400 054. Tel : 022-26106960/26106552 Fax : 022-26106052 Email: bimalokpal.mumbai@ecoigbic.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, JAIPUR – 302005. Tel: 0141-2740363 Email: bimalokpal.jaipur@ecoi.co.in
Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan, N.C. Kelkar Road, Narayanpet, PUNE – 411030. Tel: 020-32341320 Email: Bimalokpal.pune@ecoi.co.in
Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, Ground Floor; BENGALURU – 560025. Tel No: 080-26652049/26652048 Email: bimalokpal.bengaluru@ecoi.co.in
Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai PaLakhse, Main Road, Naya Bans, Sector-15, NOIDA – 201301. Tel: 0120-2514250/51/53 Email: bimalokpal.noida@ecoico.in
Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, PATNA – 800006 Tel No: 0612-2680952 Email id : bimalokpal.patna@ecoi.co.in.

This Policy is subject to regulation 17 of IRDAI (Protection of Policyholder's Interests) Regulations 2017.

Easy Health
Policy Wording

HDFC ERGO HEALTH

Schedule of benefits - Easy Health Individual

	Standard	Exclusive			Premium		
Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	1.00, 2.00, 3.00, 4.00, 5.00,7.5,10,15	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
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. 1Lakh, and maximum of Rs. 10 Lakh	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 Health Insurance Ltd.							

Easy Health
Policy Wording

HDFC ERGO HEALTH

Schedule of benefits - Easy Health Family

	Standard	Exclusive			Premium		
Sum Insured per Policy per Policy Year (Rs. in Lakh)	2.00, 3.00, 4.00, 5.00, 7.5,10,15	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. 1Lakh, and maximum of Rs. 10 Lakh	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 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		
Benefits under 3b), 3c), 3d) and 5) are subject to pre-authorisation by the HDFC ERGO Health Insurance Ltd.							

HDFC ERGO Health Insurance Limited (Formerly known as Apollo Munich Health Insurance Co. Ltd.) Registered Office: 101, First Floor, Inizio, Cardinal Gracious Road, Chakala, Opposite P & G Plaza, Andheri (East), Mumbai - 400 069, Maharashtra, India • Tel : +91 124 4584333 • Email: customerservice@hdfcergohealth.com • IRDAI Reg. No.: 131 • For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. CIN: U66030MH2006PLC331263 • UIN: HDHHLIP20131V051920. Trade Logo displayed above belongs to HDFC Ltd and ERGO International AG and used by the Company under license.