Health Wallet
Prospectus

1. Suitability:

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

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

c) There is no maximum cover ceasing age on renewals.

d) The policy will be issued for 1/2/3 year periods, the sum insured & benefits will applicable on Policy Year basis.

e) This policy can be issued to an individual and/or family.The family includes following relationships spouse, dependent children and dependent parents and dependent in laws.

f) The policy offers option of covering on individual sum insured basis and on family floater basis.

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

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

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

j) In a family floater the age of the eldest member will be considered while computing premium for the family.

k) In a individual policy Sum Insured of the Dependent insured members should be equal to or less than the Sum Insured of the primary insured member. Incase where two or more children are covered, the Sum Insured for all the children must be same. Sum insured of Dependent Parents must be the same.

Note:

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 Aged between 91 days and 25 years if they are unmarried
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 Health Wallet 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 Health Wallet Policy.
v. All Dependent parents must be financially dependent on You.
vi. An insured person who is covered as child dependent in the policy will be offered a separate individual policy at renewal with all continuity benefits on completion of 25 years.

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.

2. In-patient Benefits

Basic Sum Insured: Rs. 3Lacs; 5 Lacs; 10 Lacs; 15 Lacs; 20 Lacs; 25 Lacs; 50 Lacs on individual as well as on family floater basis.

Reserve Benefit Sum Insured: Rs. 5000; 10,000; 15,000; 20,000; 25,000 on individual and Family floater Sum Insured basis.

Optional Deductible: 2 Lac; 3Lacs; 5 Lacs & *10 Lacs (*10 Lacs deductible available for SI of 20 lacs and above)

Basic sum insured, Reserve Benefit & Optional Deductible would be available for selection in following plan options

Reserve Benefit Sum Insured	Plan / Base Sum Insured	300,000	500,000	1,000,000	1,500,000	2,000,000	2,500,000	5,000,000
	Zero Deductible	5,000	5,000	10,000	10,000	15,000	20,000	25,000
	2 Lakh Deductible	5,000	5,000	10,000	10,000	15,000	20,000	25,000
	3 Lakh Deductible	NA	5,000	5,000	10,000	10,000	15,000	15,000
	5 Lakh Deductible	NA	NA	5,000	10,000	10,000	15,000	15,000
	10 Lakh Deductible	NA	NA	NA	NA	10,000	15,000	15,000

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: Claims made under these benefits will impact eligibility for Multiplier Benefit.

	We will cover the Medical Expenses for:	In addition to the waiting periods and general exclusions, we will also not cover expenses
1.	a. In-Patient Treatment. This includes • Hospital room rent or boarding; • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	
	b. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital (In-patient, Day Care, or domiciliary hospitalization).	i) Claims which have NOT been admitted under In-patient Treatment, Day Care Procedures, or Domiciliary Hospitalization ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
	Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 90 days after discharge from the Hospital (In-patient, Day Care or Domiciliary Treatment).	i) Claims which have NOT been admitted under In-patient Treatment, Day Care Procedures, or Domiciliary Hospitalization ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
	c. Day Care Procedures Medical Expenses under 1a) Inpatient treatment on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment	i) Out-patient treatment/expenses. ii) Treatment NOT taken at a Hospital.
	d. 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: i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii. The patient takes treatment at home on account of non availability of room in a Hospital.	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 three days).
	e. Organ Donor: Ambulance section line is written here. The correct line: 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 In-patient 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.
	f. Ambulance Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to Rs. 2000 per Hospitalisation.	i) Claims which have not been admitted under In-patient Treatment and Day Care Procedures.
	g. Ayush Treatment Expenses incurred on treatment taken under Ayurveda, Unani, Sidha and Homeopathy in a AYUSH Hospital. **IMPORTANT:** This benefit is not applicable if optional Deductible is chosen.	1. Claims which have NOT been admitted under In-patient Treatment. 2. Treatment availed outside India

	h. Recovery Benefit If the Insured Person was Hospitalised beyond 10 continuous days, a lumpsum amount, as mentioned in Schedule of Benefits, will be payable. **IMPORTANT:** 1. This benefit is payable only once per Illness/Accident per Policy Year. 2. This benefit is not applicable if optional Deductible is chosen	Claims which have NOT been admitted under In-patient Treatment.
	i. Worldwide Emergency Care Expense on treatment of illness or conditions first manifested during the Policy Period while travelling overseas, provided • Hospitalisation or Day Care Procedure was necessary and was done. • up to limits specified in the Schedule of benefits. • Condition has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India. **IMPORTANT:** a. For the purpose of this benefit, Hospital means "Any institution established for In-patient treatment and Day Care Treatment of injury or illness and which has been registered as a Hospital or a clinic as per law rules and/or regulation applicable for the country where the treatment is taken. " b. Any payment will only be on reimbursement basis; c. The payment of any claim under this benefit will be based on the rate of exchange as on the date of invoice from the Hospital. The rate published by Reserve Bank of India (RBI) shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where on the date of invoice, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion; d. Our overall liability will be limited to a maximum of Rs.20 lacs; subject to Policy Sum Insured; e. General Condition 8 b) does not apply to this benefit.	
Restore Benefits.		
2.	If the Basic Sum Insured and Multiplier Benefit (if any) is exhausted due to claims made and paid during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Basic Sum Insured) will be automatically available for the particular Policy Year, provided that: a) The Restore Sum Insured will be enforceable only after the Basic Sum Insured inclusive of the Multiplier Bonus under Section 4 have been completely exhausted in that year; and b) The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1; c) The Restore Sum Insured can be used for only future claims made by the Insured Person d) No Multiplier Bonus under Section 4 will apply to the Restore Sum Insured; e) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year; f) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year. Incase Family Floater Policy, Restore Sum Insured will be available for all Insured Persons in the Policy.	Illness/Disease (including its complication) for which a claim has already been paid to the Insured Person in the current Policy Year under In-patient Benefit. **IMPORTANT**: In a Family Floater the Illness or disease will be covered in case a claim is made by any other Insured Person other than the Insured Person who has already claimed for that Illness or disease.

3. Preventive Health Check-up

At each renewal, We will reimburse expenses incurred on preventive health check-up by an Insured Person upto the amount mentioned in the table below. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

IMPORTANT: This benefit does not carry forward if it is not claimed and would not be provided if Health Wallet Policy is not renewed further.

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.

Reserve e Benefit* Sum Insured (Rs)	Plan	5000	10000	15000	20000	25000
For Non Deductible plans	Individual	Not Offered	Upto Rs 1500, per individual	Upto Rs 2500, per individual	Upto Rs 3000, per individual	Upto Rs 3500, per individual
	Family Floater	Not Offered	Upto Rs 3000, per policy	Upto Rs 5000, per policy	Upto Rs 6000, per policy	Upto Rs 7000, per policy
For Deductible plans	Individual	Not Offered	Upto Rs 1000, per individual	Upto Rs 2000 per individual	Upto Rs 2500 per individual	Upto Rs 3000 per individual
	Family Floater	Not Offered	Upto Rs 2000, per policy	Upto Rs 4000, per policy	Upto Rs 5000, per policy	Upto Rs 6000 per policy

4. Reserve Benefit

Sum Insured: Rs. 5000; 10,000; 15,000; 20,000; 25,000 on individual and Family floater Sum Insured basis.

Any claims made under this benefit will not be subject to In-patient Benefit Sum Insured and will not impact eligibility for a Multiplier Benefit. Sum Insured limit will apply on Individual basis in case of individual Sum Insured policy and on Family Floater basis in case of Family Floater Policy. Exclusions mentioned in Section 7.b. will not apply to this benefit.

- We will apply a 6% bonus on the un-utilized Reserve Benefit Sum Insured available at the end of the Policy Year irrespective whether claim is made on the expiring policy. This un-utilized Reserve Benefit Sum Insured plus the bonus amount will be carried forward to the next Policy Year.
- At each renewal the 6% bonus will be applied on the balance Reserve Benefit Sum Insured, irrespective of any change in the Basic Sum Insured or Reserve Benefit Sum Insured opted.
- The Sum Insured shown in the policy schedule will be the maximum amount that can be claimed during any given Policy Year. The available Reserve Benefit in the current Policy Year will be total of un-utilized Reserve Benefit sum insured plus bonus amount and the Reserve Benefit Sum Insured of the current Policy Year.
- Bonus on the Reserve Benefit shall not accrue if the Policy is not renewed with Us within the Grace Period.
- The mentioned bonus percentage would be reviewed annually. Change if any, to the bonus percentage shall be done post seeking prior approval from the Insurance Regulatory and Development Authority of India (IRDAI).
- The claims incurred under Reserve Benefit during a Policy Year if claimed in the subsequent Policy Year(s) would be accounted in the Policy Year in which the claim amount was incurred. In such cases the Reserve Benefit Sum Insured would be suitably adjusted at the time of renewal.

An illustration of the working of the Reserve Benefit

Consider an individual who has chosen a Reserve Benefit Sum Insured of Rs. 5000 at inception of the policy.

Policy Year	(A)	(B)	(C)	(D)	(E)	(F)	(G)
	Reserve Benefit Sum Insured Opted (Rs)	Bonus for previous Year announced on or before March 31st of the next year	Reserve Benefit Sum Insured eligible for bonus for the year (Rs) C = F (previous year) – E +A	Bonus amount (Rs) D=BXC	Amount claimed from Reserve Benefit Sum Insured during the year (Rs)	Reserve Benefit Sum Insured with Bonus amount by end of the year (Rs) F = C +D	Reserve Benefit Sum Insured available for utilization/ withdrawal (Rs) G = F +A
Year 1	5000	6%	5000	300	NA	5300	5000
Year 2	5000	6%	10300	618	0	10918	10300
Year 3	5000	6%	15918	955.08	0	16873.08	15918
Year 4	5000	6%	21873.08	1312.385	500	22685.46	21873.08
Year 5	5000	6%	27685.46	1661.128	0	29346.59	27685.46

At each subsequent renewal We will inform You of the amount available for Reserve Benefit in your policy schedule.

This benefit covers

i. Out-patient expenses. This includes

- Diagnostic Tests
- Vaccinations
- Pharmacy
- Consultations with a Medical Practioner , Physiotherapist ,Dietician, Speech therapist, Psychologist
- Dental expenses
- Special health foods and supplements

ii. Medical expenses incurred on inpatient and/or outpatient treatment. This includes

- Co-payment and / or Deductible for any health insurance claim
- Standard non-payable items under any health insurance claim
- Other Medical Expenses not covered under any medical insuranceAdditional inpatient medical expenses after exhaustion of sum insured.

iii. Continuation of cover

If the Policy has been renewed with Us for a continuous period of 5 years, then the Insured Person has an option to pay upto 50% of the renewal premium from the accrued Reserve Benefit for subsequent year(s), in such cases the portion of renewal premium would be deducted from the accumulated Reserve Benefit Sum Insured. Provided that

- We receive a written request 30 days in advance of the renewal due date from the Insured Person(s)
- There is sufficient balance in the Health expense benefit sum insured to pay that portion of renewal premium

If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated reserve benefit sum insured plus bonus amount for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with Us on a Family Floater basis then the reserve benefit sum insured plus bonus that will be carried forward for credit in such renewed Policy shall be the total of all the Insured Persons migrating to a family floater plan.

If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/individual policies then the un-utilised reserve benefit sum insured plus bonus amount of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each renewed policy

Bonus on the reserve benefit sum insured shall not accrue if the Policy is not renewed with us within the Grace Period.

5. Renewal Incentive:

Multiplier Benefit

a) If NO claim under any benefit under In-patient is made in a year and the policy is renewed with Us without any break
   i) We will apply a bonus by enhancing the renewed policy's Sum insured by 50% of the basic sum insured of the previous year's policy
   ii) The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year

   In Family Floater policy,
   i) The multiplier benefit shall be available on floater basis and accrue only if no claims have been made in respect of any Insured Person during the previous Policy Year.
   ii) Accrued Multiplier benefit is available to all insured persons under the policy

b) If a Multiplier benefit has been applied and a claim is made in any Policy Year , then in the subsequent Policy Year We will automatically decrease the accrued multiplier benefit at the same rate at which it is accrued . However this reduction will not reduce the Sum Insured below the basic Sum Insured of the policy, and only the accrued multiplier bonus will be decreased.

c) If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the multiplier bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the multiplier bonus to be carried forward for credit in the Policy would be the least multiplier bonus amongst all the Insured Persons.

d) Portability benefit will be offered to the extent of sum of previous sum insured and accrued multiplier bonus, portability benefit shall not apply to any other additional increased Sum Insured.

e) This benefit does not apply to Reserve Benefit.

6. Deductible

i. Deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for eligible Medical Expenses upto a specified rupee amount as opted and mentioned in the policy schedule i.e. it is the amount upto which the insurance company will not pay for all the claims incurred in a Policy Year under the Policy.

- The Deductible will apply on Individual basis in case of Individual Sum Insured Policy and on Family Floater basis in case of Family Floater Policy.
- A Deductible does not reduce the Sum Insured.
- If opted will apply to all Insured Person (s) under the Policy

For the purpose of calculation of amount we will consider eligible Medical Expenses incurred less the Deductible amount.

ii. Claims made under covered benefits will be payable only if the aggregate of covered Medical Expenses, in respect to Hospitalisation (s) in a policy year is in excess of the Deductible

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

7. Discounts

a. Discount of 7.5% on 2 years and 10% on 3 years policy premiums when paid on lumspsum payment mode

8. Waiting Periods and Exclusions

a) Waiting period

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

i) 30-day waiting period: Code – Excl03
   I. 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.
   II. This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.
   III. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii) Specific Disease/Procedure Waiting Period: Code – Excl02
   I. Expenses related to the treatment of the listed Conditions, surgeries/treatments as mentioned in the table below 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.
   II. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.
   III. 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.
   IV. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
   V. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
   VI. List of specific diseases/procedure:

Organ / Organ System	Illness / diagnoses (irrespective of treatments medical or surgical)	Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)
Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for Nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia

Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	Nil
Others	Nil	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/organs whether or not described above)	• Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc	• NIL

iii) Pre-existing Disease: Code Excl01

I. 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.

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

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

IV. 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.

b) General exclusions

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

Non Medical Exclusions

i) War or similar situations:

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

ii) Breach of law: Code –Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

iv) Hazardous or Adventure sports: Code-Excl09

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

Medical Exclusions

i. Investigation & Evaluation: Code Excl04

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

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

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

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

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

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

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

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

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

d. Body Mass Index (BMI)

i. Greater than or equal to 40 or,

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

1. Obesity related cardiomyopathy
2. coronary heart disease
3. severe sleep apnoea
4. uncontrolled type2 diabetes

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

v. Cosmetic or plastic surgery: Code – Excl08:Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

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

vii. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.Code – Excl13

viii. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure.Code – Excl14

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

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

xi. Sterility and Infertility –Code – Excl17 -Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

xii. Maternity:Code – Excl18

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

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

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

xiv. Aggregate Deductible - We are not liable for Claims/Claim amount falling within Aggregate Deductible limit if opted and as mentioned on the Schedule of Coverage in the Policy Schedule.

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

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

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

xviii. Congenital external diseases, defects or anomalies,

xix. Stem cell harvesting, or growth hormone therapy.

xx. Dental Treatment and surgery of any kind, unless requiring Hospitalization.

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

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

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

xxiv. Preventive care, any physical, psychiatric or psychological examinations or testing if doesn't require Hospitalization; and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

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

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

xxvii. Treatment taken on Outpatient basis

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

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

xxx. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.

xxxi. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergohealth.com

xxxii. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

9. Claim Procedure

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

a) Intimation & Assistance - Please contact HDFC ERGO Health atleast 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact HDFC ERGO Health within 24 hours of the event.

b) Procedure for Reimbursement of Medical Expenses

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

  * Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by you, HDFC ERGO Health Insurance Ltd. will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents, HDFC ERGO Health will send admissible amount, along with a settlement statement within 30 days.
- The payment will be made in the name of the Policyholder.

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

c) Claim Procedure to avail Cashless facility -

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

Note:

- Insured person is entitled for cashless coverage only in our empanelled hospitals.
- Please refer to the list of empanelled hospitals on our website or the list provided along with Policy kit or call us on our toll free number at 1800-102-0333.
- Rejection of cashless facility in no way indicates rejection of the claim.

d) Claim Procedure for claims under Reserve Benefit

- The claim settlement at network centers would be on cashless basis
- In case of non network centers, the claim would be settled on reimbursement basis.
- Reimbursement amount will be credited into insured's account via NEFT.

10. Renewal of Policy:

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break

in policy. Coverage is not available during the grace period.

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

11. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

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

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

13. Pre- Policy Check-up:

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

- **Pre-Policy Check-up Grid:**

Restore grid				
Age\Sum At Risk (SAR)	**<=3 lacs**	**>3lacs and <=5 lacs**	**>5 lacs and <=10 lacs**	**>10 lacs**
<18	NM	NM	NM	NM
18-45	NM	NM	NM	Cat 6 (MER, FBS, TMT, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)
46-55	Cat 2 (MER, FBS, ECG, TC, Sr Creatinine)	Cat 2 (MER, FBS, ECG, TC, Sr Creatinine)	Cat 6 (MER, FBS, TMT, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)	Cat 6 (MER, FBS, TMT, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)
56-60	Cat 3 (MER, FBS, ECG, Lipids, Sr Creatinine)	Cat 6 (MER, FBS, TMT, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)	Cat 6 (MER, FBS, TMT, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)	Cat 6 (MER, FBS, TMT, Lipids, Sr creatinine, LFT, Sr uric acid, USG Abd)
61-65	Cat 7 (MER, FBS, ECG, 2D ECHO, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)	Cat 7 (MER, FBS, ECG, 2D ECHO, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)	Cat 7 (MER, FBS, ECG, 2D ECHO, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)	Cat 7 (MER, FBS, ECG, 2D ECHO, Lipids, Sr Creatinine, LFT, Sr uric acid, USG Abd)

14. Loadings

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 enhancement in sum insured (for the enhanced Sum Insured).

For Example: Consider a male aged 35 who is undergoing treatment for hypertension.

Age	Hypertension	Treatment	Systolic	Diastolic	loading
35	Yes	Yes	110-145	70-95	10%
35	Yes	Yes	146-160	70-95	20%
35	Yes	Yes	110-140	96-105	20%
35	Yes	Yes	>160	Any	Reject
35	Yes	Yes	Any	>105	Reject

Please note that this example is for enumerative purposes only, the decisions may vary based on age, co morbidities etc.

a) We will inform You about the applicable risk loading or exclusion or both as the case may be 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 7 days, We shall cancel Your application and refund the premium paid within next 7 days.

b) The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section 3 A i),ii) & iii) of the policy wordings or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

c) Please note that We will issue Policy only after getting Your consent and additional premium, if any.
d) We will not apply any additional loading on your policy premium at renewal based on claim experience.
e) Please visit our nearest branch to refer our underwriting guidelines, if required.

15. Cancellation (other than Free Look Period):

a. In-patient Benefit

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

Length of time Policy in force	% of premium refunded
Upto 1 Month	75.00%
Upto 3 Months	50.00%
Upto 6 Months	25.00%
Exceeding 6 Months	Nil

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

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

b. Reserve Benefit

In case Your policy is terminated in conjunction with point a)) as above or is not renewed with Us in time including the grace period, then the accumulated Reserve Benefit as show in the Policy Schedule would be available for reimbursement without any further credit of bonus amount,

And

In case of the demise of the sole Insured Person, the accumulated Reserve Benefit as show in the Policy Schedule would be available to the nominee for reimbursement under this plan.

16. Others

a) Portability:

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

For Detailed Guidelines on Portability, kindly refer the link

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

b) Free Look Period:

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

c) Migration

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

For Detailed Guidelines on Migration, kindly refer the link

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

d) Moratorium Period

After completion of eight continuous years under this Policy no look back would be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this Policy shall be contestable except for proven fraud, permanent exclusions, Co-payment and Deductible specified in the Policy. The Policy would however be subject to all limits, sub limits, co-payment, Deductible, Aggregate Deductible and other terms as specified in Schedule of Coverage on the Policy Schedule

e) Non Disclosure or Misrepresentation:

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

a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule without refunding the premium amount; and

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

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

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

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

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

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

f) Fraud:

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

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

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

g) Payment Facility:

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

h) Renewability

- There shall be no cover ceasing age on renewal.

i) Tax Benefit:

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

j) Requirement:

- Completed proposal form

17. Schedule of Benefits

Schedule of benefits - Health Wallet Individual	
Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00, 20.00, 25.00 & 50,00
1a) In-patient Treatment	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 90 Days
1d) Day Care Procedures	All Day Care Procedures Covered
1e) Domiciliary Treatment	Covered
1f) Organ Donor	Covered
1g) Ambulance	Upto Rs.2,000 per Hospitalisation

1h) Ayush Treatment	Covered
1i) Recovery Benefit **This benefit is not applicable if optional Deductible is chosen**	Rs 10,000 for hospitalisation exceeding consecutive 7 days
1j) Worldwide Emergency Care	50% of Sum Insured upto a maximum of Rs.20 lacs
2) Restore Benefit	Equal to 100% of Basic Sum Insured
3) Preventive Health Check-up	As per grid mentioned in the benefit
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal
5) Reserve Benefit per Insured Person per Policy Year (Rs)	5,000; 10,000; 15,000; 20,000 & 25,000
6) Deductible (Optional) per Insured Person per Policy Year (Rs in Lakh)	2.00; 3.00; 5.00 & *10.00 *10.00 deductible available for SI of 20 lacs and above

Schedule of benefits Health Wallet - Family Floater	
Basic Sum Insured per Policy per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00, 20.00, 25.00 & 50,00
1a) In-patient Treatment	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 90 Days
1d) Day Care Procedures	All Day Care Procedures Covered
1e) Domiciliary Treatment	Covered
1f) Organ Donor	Covered
1g) Ambulance	Upto Rs.2,000 per Hospitalisation
1h) Ayush Treatment	Covered
1i) Recovery Benefit **This benefit is not applicable if optional Deductible is chosen**	Rs 10,000 for hospitalisation exceeding consecutive 7 days
1j) Worldwide Emergency Care	50% of Sum Insured upto a maximum of Rs.20 lacs
2) Restore Benefit	Equal to 100% of Basic Sum Insured
3) Preventive Health Check-up	As per grid mentioned in the benefit
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal
5) Reserve Benefit per Insured Person per Policy Year (Rs)	5,000; 10,000; 15,000; 20,000 & 25,000
6) Deductible (Optional) per Insured Person per Policy Year (Rs in Lakh)	2.00; 3.00; 5.00 & *10.00 *10.00 deductible available for SI of 20 lacs and above

18. Premium Chart:

a) The premium under individual coverage will be charged on the completed age of the individual insured member and for family floater coverage the premium will be considered on the completed age of the eldest insured member.
b) The premium for the policy will remain the same for the Policy Period mentioned in the policy schedule.
c) Please note that your premium at renewal may change due to a change in your age or changes in the applicable tax rate.
d) Premium rates are subject to change with prior approval from IRDAI.
e) The Sum Insured of the dependent insured members should be equal to or less than the Sum Insured of the Primary Insured member. Incase where two or more children are covered, the Sum Insured for all the children must be same. Sum insured of all Dependent Parents and Dependent Parent in law must be same.
f) 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

PI Note. Premium rates and policy terms and conditions are for standard healthy individuals. These may change post underwriting of proposal based on medical tests (where applicable) and information provided on the proposal form.

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published

prospectuses or tables of the insurers.

2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI.

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

Annexure I – List of Non-Medical Expenses

S.No	List of Non Medical Expenses
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSpITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HTNGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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