HDFC ERGO General Insurance Company Limited

Policy Wordings

OPTIMA SENIOR

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Preamble

HDFC ERGO General Insurance Company Limited 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 A. Definitions

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:

I. Standard Definitions

Def. 1. Accident or Accidental means a sudden, unforeseen and involuntary event caused by external and visible means (but does not include any Illness) which results in physical bodily injury.

Def. 2. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 3. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion

i. Having qualified registered AYUSH Medical Practitioner (s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def.3. Congenital Anomaly means a condition 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. 4. Disclosure to 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. 5. 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 Conditions. Coverage is not available for the period for which no premium is received.

Def. 6. 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. 7. Hospitalisation or Hospitalised means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 8. 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.9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. Migration means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def. 15. Network 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. 16. Non Network means any Hospital, day care centre or other provider that is not part of the Network

Def. 17. Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another

Def. 18. Pre-existing Condition means any condition, ailment, injury, or disease:

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

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

Def. 19. 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. 20. 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. 21. Reasonable 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 by comparable providers, taking into account the nature of illness/ injury involved

Def. 22. 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. 23. 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.

II. Specific Definitions

Def. 1. Adventurous/Hazardous Sports means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

Def. 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, Homeopathy, Yoga & Naturopathy in the Indian context

Def. 4. **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 5. Bank Rate shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due

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

Def. 7. Material facts for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk

Def. 8. Policy means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any) and the Schedule (as the same may be amended from time to time).

Def. 9. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 10. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 11. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 12. We/Our/Us means the HDFC ERGO General Insurance company Ltd.

Def. 13. You/Your/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

Section B. Benefits

I. Coverages

The following benefits are available to all Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or treatment defined as a Day Care Procedure. Any claims made under these benefits will impact eligibility for a "No claim discount".

	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 C-I,II,III
1	a. In-Patient Treatment <u>Note pertaining specifically to AYUSH Treatments only:</u> Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.	1. Prosthetics NOT implanted by surgery 2. Hospitalisation for evaluation, Investigation only 3. Treatment availed outside India 4. Treatment at a healthcare facility NOT conforming to Hospital definition.
	b. Pre-Hospitalization Medical expenses for consultations, investigations and medicines incurred upto 30 days before Hospitalisation. c. Post-Hospitalization Medical expenses for consultations, investigations and medicines incurred upto 60 days after discharge from Hospitalisation.	1. Claims which have NOT been admitted under 1a), 1d), and 1 e) 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required.

	d. Day Care Procedures Medical treatment, and/ or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre for less than 24 hours because of technological advancement, which would have otherwise required a hospitalisation of more than 24 hours.	5. Out-Patient Treatment 6. Treatment at a healthcare facility NOT conforming to Hospital definition
	e. Domiciliary Treatment	1. Treatment of less than 3 days
	f. Organ Donor: Medical treatment of the organ donor for harvesting the organ.	1. Claims which have NOT been admitted under 1a). 2. Claims not covered under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
	g. Emergency Ambulance: Expenses incurred on an ambulance in an emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under 1a). 2. A non- Emergencies. 3. NON registered healthcare or ambulance service provider ambulances.
Additional Benefit: The following benefit is available to all Insured Persons during the Policy Period. Claims made under this benefit will not impact eligibility for a "No claim discount"		

2	a. E-Opinion 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.	1. More than one claim for this benefit in a Policy Year. 2. More than one claim for the same Critical Illness. 3. 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.

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.

In-patient Treatment means treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.

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

Out-patient Treatment means consultation, diagnosis or medical treatment taken by an Insured Person at an out-patient department of a Hospital, clinic or associated facility, provided that he is not Hospitalised.

Domiciliary treatment means medical treatment for a period exceeding 3 days, for an Illness/disease/injury

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 Insured Person is such that he is not in a condition to be removed to a Hospital or,
2. The Insured Person takes treatment at home on account of non availability of room in a Hospital.

Important terms You should know.

Medical Practitioner means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction, and is acting within the scope and jurisdiction of his license.

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

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

II. **Renewal Benefits**:

No Claim Discount - A 5% non-cumulative discount will be offered on the renewal premium payable under the Policy after every CLAIM FREE Policy Year, provided that the Policy is renewed with Us and without a break.

III. **Special terms and conditions**

Co-Payment

'Co-Payment' means a cost-sharing requirement applicable under this Policy in which the Insured Person will bear the percentage of the admissible claim amount which is specified in the table below. A Co-Payment does not reduce or otherwise affect the Sum Insured.

A. Co-Payment applicable on accommodation Type

Accommodation Type	Co-Payment (Percentage to be borne by the Insured Person as a percentage of the admissible claim amount)
Shared Accommodation or any lower accommodation type	15%
Single occupancy or any higher accommodation type	30%

Note –

If any urgent medical and/or surgical treatment is taken for acute cardiac Illness or Accident to avoid serious impairment of health in a single occupancy accommodation due to unavailability of Shared or any lower accommodation then only a 15% Co-Payment would be applicable.

A Co-payment of 15% shall be applicable to all Day Care Procedures; no additional copay's shall apply.

B. Co-Payment applicable on specified Illnesses/ surgeries

If a claim has been admitted under Section B.I in respect of any of the following Illnesses/Surgeries then, the insured person shall bear 30% of the claim amount payable under the Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

S.no	Illnesses/Surgeries
i.	Cataract (each eye)
ii.	Hysterectomy
iii.	Cholecystectomy
iv.	Transurethral resection of the prostate (TURP)/ Benign prostate surgery
v.	Surgery of Hemia
vi.	Angiography (CT Angiogram excluded)
vii.	Arthroscopy
viii.	PID-Discectomy
ix.	Mastectomy
x.	Joint Replacement
xi.	PTCA (Angioplasty)
xii.	Hydrocele
xiii.	Major Organ Transplant
xiv.	CABG

Note – If We admit a claim under Section B.III B then, no Co-Payment shall be applicable under Section B.III A for the same claim.

Section C. Exclusions & Waiting Period

I. **Standard Waiting Period**

All claims payable will be subject to the waiting periods specified below:

i) 30-day Waiting period: Code – Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments 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.

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

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedure:

Sl No	Organ / Organ System	Illness	Treatment
a	ENT	• Any benign ear, nose and throat (ENT) disorder Example: Sinusitis, Rhinitis	• Any ear, nose and throat (ENT) surgery Example: adenoidectomy, mastoidectomy, tonsillectomy, tympanoplasty • surgery for nasal septum deviation
b	Gynaecological	• Internal tumors, cysts, nodules, polyps including breast lumps • Polycystic ovarian diseases	• Dilatation and curettage (D&C) • Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus • Myomectomy for fibroids
c	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Age related Osteoarthritis and Osteoporosis	• Surgery for prolapsed inter vertebral disk • Joint replacement
d	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Pancreatitis • Fissure/ fistula in anus, hemorrhoids, pilonidal sinus • Gastric and duodenal ulcers • All forms of cirrhosis	• surgery of gallbladder and bile duct • surgery of hernia
e	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate	• Any surgery of Urogenital system • Surgery on prostate • Surgery for Hydrocele
f	Eye	• Cataract • Glaucoma	• Nil
g	Others	• Internal tumors, cysts, nodules, polyps, skin tumors	• Surgery of varicose veins and varicose ulcers

iii) Pre-Existing Diseases: Code – Excl01

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

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

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

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

Important terms You should know.

Pre-existing Condition means any condition, ailment, injury or disease:
i) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
ii) For which Medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

II. **Standard General exclusions**

We will not pay for any claim in respect of any Insured Person arising from:

Non-Medical Exclusions	i) 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. ii) 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	iii) 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. vi) 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. v) 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 vi. 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. vii. 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. vii. Excluded Providers- Code – Excl11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim. viii. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code – Excl12 ix. 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

	x. 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 xi. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. Code – Excl15 xii. 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 xiii. 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 xiv. 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.

III. **Specific Exclusions**

Non-Medical Exclusion	iv) War or similar situations: 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. v) Intentional self-injury or attempted suicide while sane or insane

Medical Exclusions	i. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound. ii. Any Insured Person's participation or involvement in naval, military or air force operation. iii. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition"). iv. Congenital external diseases, defects or anomalies, v. Stem cell harvesting vi. Investigative treatments for analysis and adjustments of spinal subluxation,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). vii. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment). viii. Any Convalescence, ,sanatorium treatment, private duty nursing or long-term nursing care. ix. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. x. Vaccination including inoculation and immunisations (Except post Animal bite treatment), xi. 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.hdfcergo.com. xii. Treatment taken on Outpatient basis xiii. The provision or fitting of hearing aids, spectacles or contact lenses. xiv. 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.

	xv. 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. xvi. 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.hdfcergo.com xvii. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form. xviii. Any non-allopathic treatment except to the extent of coverage provided for under 'In-patient treatment' cover. xix. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. xx. 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 xxi. Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines

Section D. General Terms & Clauses

I **Standard General Terms & Clauses**

a) Conditions Precedent to Admission of Liability
The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

b) Disclosure of Information
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

c) Claim Settlement (Provision for Penal Interest)
   a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
   b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
   c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
   d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

d) Complete Discharge
Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

e) 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 specified in the policy contract.
The Policy would however be subject to all limits, sub limits, co-payments, Deductibles as per the policy contract.

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

h) 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.

i) 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.

j) 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.

k) 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

l) 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

m) 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.

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

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

1 Year Policy Period		**2 Year Policy Period**	
Length of time Policy in force	**% 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	50.00%
		Upto 15 Months	37.50%
		Upto 18 Months	25.00%
		Exceeding 18 Months	Nil

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

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.

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

q. Grievance Redressal Procedure
In case of any grievance the insured person may contact the company through:

- Website: www.hdfcergo.com
- Toll free: 022 6234 6234 / 0120 6234 6234
- Contact Details for Senior Citizen: 022-6242-6226 | seniorcitizen@hdfcergo.com
- E-mail: grievance@hdfcergo.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at cgo@hdfcergo.com

For updated details of grievance officer, kindly refer the link: https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call: 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call: 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call: 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call: 022 6242 6226 Email id: seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call: 022 6242 6226 Email id: seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call: 022 6242 6226 Email id: seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
Visit us	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai - 400 078.	Chief Grievance Officer, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai - 400 078.

i. If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

II. Specific General Terms & Clauses

a. Geography

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

b. 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.

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.

c. Loadings

We may apply a risk loading on the premium payable (based on the declarations made in the proposal form and the health status of the persons proposed for insurance) at the Commencement Date or on any renewal of the Policy with Us or on the receipt of a request for enhancing the Sum Insured. The maximum risk loading applicable for an individual will not exceed 100% per diagnosis / medical condition and an overall risk loading of 150% per individual

We will send You the applicable risk loading in writing. You shall give Us Your consent and the additional premium (if any), within 15 days of the issuance of Our letter. If You neither accept Our letter nor revert to Us within 15 days, We will cancel Your application and refund the premium paid within the next 7 days.

d. Notification of Claim

	Treatment, Consultation or Procedure:	We or Our TPA must be notified:
i)	Any treatment for which a claim may be made requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	Any treatment for which a claim may be made requires Hospitalisation in an Emergency:	Within 24 hours of the start of the Insured Person's Hospitalisation.

e. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	Notice period for the Insured Person to take advantage of the cashless service*: *Written notice must be accompanied by full particulars.
i)	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.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	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 of the start of the Insured Person's Hospitalisation.

f. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with any documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the either 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 with detailed breakup of charges (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) Original payment receipts

iv) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.

v) Discharge Summary, with Date of admission and discharge, clinical history, past history, procedure details and details of treatment taken

vi) Invoice/Sticker of the Implants.

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

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

ix) 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.

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 cost towards performing such medical examination (at the specified location) of the Insured Person.

g. Claims Payment

ii) We will 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 or Our TPA 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.

iii) We will only make payment to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of Your death, We will make payment to the Nominee (as named in the Schedule). The assignment of benefits of the policy shall be subject to applicable law.

iv) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

h. 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:

- cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy

may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule ; and

- the claim under such Policy if any, shall be 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 j i) above.

i. 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.

j. 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, other person or entity is authorised to receive any notice on Our behalf unless explicitly stated in writing by Us.

k) 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.

Section E. Others

I. Claim Related Information

	Within India	Outside India
Claim Intimation:	Customer Service No. 022-62346234 / 0120- 62346234 Email: healthclaims@hdfcergo.com	Toll Free No: 800 08250825 Global Toll Free No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email: travelclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1, 5th Floor, C - 25, Noida, Sector 62, 201301,Uttar Pradesh

II. List of Ombudsman

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Rajasthan.

ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.

LUCKNOW - Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane

IRDA REGULATION NO 12: This Policy is subject to regulation 12 of IRDA (Protection of Policyholder's Interests) Regulation 2017.

Endorsements – Optima Senior

a) 30 days waiting period

The 30 days waiting period under Section C-I- i) stands deleted for all the Insured Persons.

b) 24 months waiting period for specified Illnesses/ surgeries

i) The 24 months waiting period for the specified Illnesses/ Surgeries specified under Section C-I-ii) stands deleted for all the Insured Persons.

ii) The 24 months waiting period for the specified Illnesses/ Surgeries specified under Section C-I-ii) stands reduced to 12 months for all the Insured Persons.

c) 36 months waiting period for Pre-existing Conditions

i) The 36 months waiting period for the Pre-existing Conditions under Section C-I-iii) stands deleted for all the Insured Persons.

ii) The 36 months waiting period for the Pre-existing Conditions under Section C-I-iii) stands reduced to 24 months for all the Insured Persons.

iii) The 36 months waiting period for the Pre-existing Conditions under Section C-I-iii) stands reduced to 12 months for all the Insured Persons.

Annexure I – List of Non-Medical Expenses

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