Maxima, Policy - Prospectus

Suitability

- This policy covers persons in the age group 91 days onwards. The maximum entry age is 65 years.
- There is no maximum cover ceasing age in this policy.
- The policy will be issued for a period of 1 year.
- This policy can be issued to an individual and/or family. The family coverage in on floater basis and the coverage will be available for two members & two adults + upto 2 children.
- The family includes spouse, dependent children and dependent parents.
- The premium under floater coverage will be charged on the age of the eldest insured member.

Salient Features & Benefits

Out-patient Module

We will issue Entitlement Certificate to the Insured Person for availing Out-patient benefits within the Network service provider. Reimbursement of expenses for OPD consultation, Diagnostic Tests, Pharmacy, Out-patient Dental Treatment, and Spectacles, Contact Lenses would be done in cases where the member visits a non-network provider. For Annual Health Check-Up benefit, no reimbursement is allowed.

1. **Out-patient Consultations** - Out-patient consultations by a general Medical Practitioner(s) or a specialist Medical Practitioner(s).
2. **Diagnostic Tests -** Out-patient diagnostic tests taken by the Insured Person from a diagnostic centre (not necessarily to be prescribed by Network Medical Practitioner).
3. **Pharmacy -** Medicines purchased by the Insured Person from a pharmacy, provided that such medicines have been prescribed in writing by a Medical Practitioner (not necessarily to be Network Medical Practitioner).
4. **Out-patient Dental Treatment -** Any necessary dental treatment taken by an Insured Person from a dentist provided that We will not pay for any dental treatment that comprises cosmetic treatment.
5. **Spectacles, Contact lenses -** Either one pair of spectacles or contact lenses, provided that these have been prescribed for the Insured Person by a Eye specialist Medical Practitioner(s).
6. **Annual Health Check Up within specified Network -** A health check-up for the Insured Person within Network . [This benefit is not available to the Insured Persons above the age of 45 years in the first Policy Year and to the Insured Persons below 18 years of age.]

   Out-patient benefit Network is available in following cities (Chennai, Delhi, Mumbai, Hyderabad, Bengaluru, Ahmedabad, Kolkata). The list of network service providers is available on Our website www.hdfcergo.com.

   If an Entitlement Certificate has been used and results in treatment to which In-patient Module responds, then We would be refunding the Entitlement Certificate used for pre-hospitalisation by issuing fresh Entitlement Certificate.

In-patient Module

1. **In-patient Treatment -** It covers hospitalisation expenses due to an illness or accident. We will pay for the medical expenses for Room rent, boarding expenses, Nursing, Intensive care unit, Medical Practitioner(s), Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, Medicines, drugs and consumables, Diagnostic procedures, Cost of prosthetic & other devices or equipments if implanted internally during a Surgical Procedure.

   Note pertaining specifically to AYUSH Treatments only:

   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.
2. **Pre-Hospitalisation Medical Expenses -** The Medical Expenses incurred in 30 days immediately before the Insured Person was hospitalised. It can be increased to 60 days if claim is intimated 5 days before hospitalisation.
3. **Post-Hospitalisation Medical Expenses -** The Medical Expenses incurred in 60 days immediately after the Insured Person was discharged post- hospitalisation. It can be increased to 90 days if claim is intimated 5 days before hospitalisation.
4. **Day Care procedures -** The Medical Expenses for Day care procedures which do not require 24 hours hospitalisation due to technological advancement.
5. **Domiciliary Treatment -** The Medical Expenses incurred by an Insured Person for availing medical treatment at his/her home which would otherwise have required Hospitalisation.
6. **Organ Donor -** The Medical Expenses for an organ donor's treatment for the harvesting of the organ.
7. **Emergency Ambulance -** Expenses upto ₹ 2,000 per hospitalisation for utilizing ambulance service for transporting Insured Person to Hospital in case of an emergency or from one hospital to another if medical services required are not available.
8. **Maternity Expenses -** Medical Expenses for maternity including pre-natal and post-natal expenses after a waiting period of 4 years.
9. **Newborn baby -** Optional coverage for newborn from birth (Day 1 - 90) for In-patient Treatment benefit, subject to acceptance of proposal and premium payment in full.
10. **Daily Cash for choosing shared accommodation -** Per Day cash amount per day if the Insured Person is hospitalised in shared accommodation in a Network Hospital and hospitalisation exceeds 48 hrs.
11. **Daily Cash for accompanying an Insured Child -** Per day cash amount for 1 accompanying adult if insured child under 12 years is hospitalised and hospitalisation exceeds 72 hrs.

    Optional Benefit: Critical Illness benefit provides lumpsum benefit for listed Critical Illness. The benefit amount is payable once the Critical Illness is diagnosed during the policy period and the Insured Person survives 30 days after the diagnosis. This benefit can be opted on payment of additional premium. This benefit if opted is applicable to all family members on Individual Sum Insured Basis equivalent to ₹ 300,000/-. This benefit will not be renewed beyond 70 years of age.

    Sum Insured: In-patient Sum Insured per policy of ₹ 300,000. Out-patient Sum Insured per policy as mentioned in Schedule of benefits and Critical Illness (Optional Benefit) Sum Insured per Insured ₹ 300,000/-.

Renewal Incentives:

- **Out-patient Module**

  Carry Forward Bonus - If any available Entitlement Certificates are not used by Insured Person in a Policy Year, then We will carry forward 50% of these Entitlement Certificates to the next Policy Year except for Annual Health Check-Up.

  Process for obtaining Carry Forward Entitlement Certificates

  You have to send us all unused entitlement certificates before renewal (grace period of 15 days from the due date of renewal can be provided). After verifying the entitlement certificates and checking the admissibility of Carry Forward Bonus as mentioned above, fresh entitlement certificates will be issued within 30 days of the receipt of the unused entitlement certificates provided that the policy is renewed with Us without a break.

- **In-patient Module:**

  Cumulative Bonus - We will offer Cumulative bonus of 10% of the Sum Insured for every claim free year accumulating up to 50%. In the event of a claim, the Cumulative bonus will be reduced by 10% of sum insured on renewal.

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.

Maxima, Policy - Prospectus

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

Exclusions: [Applicable to In-patient Module and Critical Illness benefit]

A. Waiting Periods

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

i) 30-day waiting period - Code Excl03

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

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

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

ii) Specified Disease/Procedure waiting period - Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/ treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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/procedures:-

i. Illnesses: arthritis if non infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/fistula in anus, hemorrhoids, pilonidal sinus, gastric and duodenal ulcers; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); osteoarthritis and osteoporosis; polycystic ovarian diseases; sinusitis and Rhinitis,Tonsilitis and skin tumors unless malignant.

ii. Treatments: benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy; joint replacement; myomectomy for fibroids; surgery of gallbladder and bile duct unless necessitated bymalignancy; surgery of genito urinary system unless necessitated by malignancy; surgery of benign prostatic hypertrophy; surgery of hernia; surgery of hydrocele; surgery for prolapsed inter vertebral disk; surgery of varicose veins and varicose ulcers; surgery on tonsils and sinuses; nasal septum deviation.

Note: In case a new born is diagnosed with an Internal Congenital Disease related to any of the above listed diseases/procedures, then Specific waiting period (Code – Excl02) for such disease/procedure shall not apply to that new born for life, who are covered under this policy without any break.

iii. **Pre-Existing Diseases - Excl01**

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

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

c) If the insured person is continuously covered without any break as defined under the portability 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 48 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:

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. **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.

vii. **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.

viii. **Excluded Providers:** Code11 - 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.

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

x. 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

xi. 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

xii. Refractive Error: Code - Excl15 – Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

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

xiv. **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

xv. **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.

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

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

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

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

xx. Congenital external diseases, defects or anomalies,

xxi. Stem cell harvesting.

xxii. Investigative treatment 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).

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

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

xxv. 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.

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

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

xxviii. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family, or stays with him,

xxix. Treatment taken on Outpatient basis

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

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

xxxii. 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.

xxxiii. 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.

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

xxxv. Any non allopathic treatment except to the extent of coverage provided for under 'In-patient treatment' cover under Part B – In patient module.

Renewal

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

i. The Company shall endeavour 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.

Non-Disclosure or Misrepresentation:

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

a) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule; and

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

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/

Misrepresentation of Pre-existing diseases subject to your prior consent;

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

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

c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later. The above options will not prejudice the rights of the Company to invoke cancellation under clause i above.

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.

Detailed Guidelines on Migration are available at https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

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. Detailed Guidelines on Portability are available at https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

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.

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.

Claim Procedure:

All claims under this policy will be processed and settled by specified (HDFC ERGO General Insurance Company Limited) licensed by IRDA.

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

Procedure for Reimbursement of Medical Expenses

- HDFC ERGO General Insurance Company Limited must be informed no later than 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/ documents mentioned therein to HDFC ERGO General Insurance Company Limited within 15 days of the occurrence of the Incident.

* Please refer to claim form for complete documentation.

- If there is any deficiency in the documents/information submitted by you, HDFC ERGO General Insurance Company Limited will send the deficiency letter within 7 days of receipt of the claim documents.
- The payment will be made in the name of the proposer.
- Claim settlement (Provision for penal interest)
  - 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.
  - 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.
  - 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.
  - 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.

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

Procedure to avail Cashless facility

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

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 Customer care at 022 6234 6234 / 0120 6234 6234.
- Rejection of cashless facility in no way indicates rejection of the claim.

Process for Reimbursement of OPD Benefits in non-network providers

- Reimbursement of expenses for OPD consultation, Diagnostic Tests, Pharmacy, Out-patient Dental Treatment, and Spectacles/Contact Lenses would be done in cases where the member visits a non-network provider. Annual Health Check-Up benefit can be availed only at network provider.
- Please submit the duly signed Original Entitlement Certificate along with the original payment receipt, prescription and ID card to HDFC ERGO General Insurance Company Limited on completion of service.
- Only original copies of the Entitlement Certificate shall be valid.

Maxima, Policy - Prospectus

- The Entitlement Certificate may be used by the Insured Person(s) whose name is mentioned on the entitlement certificate.
- Reimbursement will be made for the fixed amount as mentioned in Entitlement Certificate or actual payment made.

Requirement

- Completed proposal form
- Pre Policy Check-up (PPC) depending on the age and sum insured. For accepted PPC cases, we will reimburse 100% of the expenses incurred subject to maximum of ₹ 2,000/- per insured person.

Premium Rates

- Annual Premium in ₹ [Excluding Goods & Services Tax & Cess (if any)] Base Product*

Age Group	1 Member	2 Members**	2 Adults + upto 2 Children**
0-17	12,682	-	-
18-45	13,795	19,135	25,810
46-60	16,910	23,585	30,705
> 60	24,831	35,778	42,720

**Premium will be computed considering age of eldest member Optional Benefit Critical Illness* [On individual Sum Insured basis]

Age Group	Sum Insured ₹ 300,000
0-17	92
18-45	785
46-60	3,741
61-70	10,983

- The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.
- Please note that your premium at renewal may change due to a change in your age or changes in the applicable tax rate.
- Premium rates are subject to change with prior approval from IRDA.

Avail tax benefit for the premium amount under section 80D of Income Tax Act

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

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

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, we shall cancel your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after getting Your consent.

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

Schedule of Benefits

<table>
<tr><td colspan="4">Part A- Out-patient Module</td></tr>
<tr><td>Sum Insured per Policy</td><td>1 Member</td><td>2 Members</td><td>2 Adults + upto 2 Children</td></tr>
<tr><td>a) Out-patient Consultations*</td><td>4 Consultations</td><td>6 Consultations</td><td>8 Consultations</td></tr>
<tr><td>b) Diagnostic Tests#</td><td rowspan="4">₹ 5,000</td><td rowspan="4">₹ 5,500</td><td rowspan="4">₹ 7,000</td></tr>
<tr><td>c) Pharmacy#</td></tr>
<tr><td>d) Out-patient Dental Treatment#</td></tr>
<tr><td>e) Spectacles, Contact Lenses#</td></tr>
<tr><td>f) Annual Health Check-up within specified Network^</td><td>1 Entitlement Certificate</td><td>2 Entitlement Certificates</td><td>2 Entitlement Certificates</td></tr>
<tr><td colspan="4">* The reimbursement against non-network Out-patient Consultations is restricted up to lower of actual expenses or ₹ 400.
The reimbursement against non-network Diagnostic Tests, Pharmacy, Out-patient Dental Treatment, Spectacles, Contact Lenses is restricted up to lower of actual expenses or the Sum Insured mentioned above.
^ One Entitlement Certificate of Annual Health Check-up includes following tests: HB, PCV, RBC, MCHC, MCV, MCH, Total WBC, Differential Count, ESR, PLT, Peripheral Smear, Complete Urine Analysis, GTT, Serum Calcium, Serum Creatinine, Lipid Profile (Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Triglycerides, Cardiac Risk Ratio), Liver Function Test (Total Protein, Albumin, Globulin, Total bilirubin, ALT, AST, GGTP), Blood group, ECG (Resting), X-ray (Chest), Ultrasound (Upper abdomen screening), Consultation by General Physician, Consultation by Gynecologist.</td></tr>
<tr><td colspan="4">Part B- Inpatient Module</td></tr>
<tr><td></td><td>1 Member</td><td>2 Members</td><td>2 Adults + upto 2 Children</td></tr>
<tr><td>Sum Insured per Policy</td><td>₹ 300,000</td><td>₹ 300,000</td><td>₹ 300,000</td></tr>
<tr><td>a) In-patient Treatment</td><td colspan="2">Covered</td><td></td></tr>
<tr><td>b) Pre-Hospitalization</td><td colspan="3">30 days; can be increased to 60 days</td></tr>
<tr><td>c) Post-Hospitalization</td><td colspan="3">60 days; can be increased to 90 days</td></tr>
<tr><td>d) Day Care Procedures</td><td colspan="2">Covered</td><td></td></tr>
<tr><td>e) Domiciliary Treatment</td><td colspan="2">Covered</td><td></td></tr>
<tr><td>f) Daily Cash for choosing Shared Accommodation</td><td colspan="2">₹ 500 per day, Maximum ₹ 3,000</td><td></td></tr>
<tr><td>g) Organ Donor</td><td colspan="2">Covered</td><td></td></tr>
</table>

Maxima, Policy - Prospectus

Part B- Inpatient Module		
h) Emergency Ambulance	Upto ₹ 2000 per hospitalisation	
i) Daily Cash for accompanying aninsured child	₹ 300 per day; Maximum ₹ 9,000	
j) Maternity Expenses ** Waiting Period 4 years	Normal Delivery- ₹ 15,000; Caesarean Delivery - ₹ 25,000 (Including Pre/Post Natal limit of ₹ 1,500 and Infant baby limit of ₹ 2,000)	
k) Newborn baby cover	Optional	
Optional Benefit		
Critical Illness **[Offered on Individual Sum Insured basis]	₹ 300,000	

* *These benefits do not dip into In-patient Sum Insured

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

S. No	List of Non Medical Expenses
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

Maxima, Policy - Prospectus

Premium / Benefit Illustration
In-Patient Sum Insured - 3,00,000
Out-Patient Benefits - As mentioned below
Tenure – 1 Year

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of (0% i.e. no family discount applicable)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
7	12,682	3	12,682	0	12,682	3	25,810	NA	25,810	3
10	12,682	3	12,682	0	12,682	3		NA		
35	13,795	3	13,795	0	13,795	3		NA		
40	13,795	3	13,795	0	13,795	3		NA		
	52,954				**52,954**				**25,810**	
	Total premium for all members of the family is Rs. 52,954 when each member is covered separately.		Total premium for all members of the family is Rs. 52,954 when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs. 25,810			
	Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate		Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate				Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 8 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 7,000 3. Annual Health Check-Up within specified network - 2 entitlement certificate			

Premium as mentioned above are exclusive of taxes.

Above premium examples are for Illustration purpose only, terms and conditions apply.

Maxima, Policy - Prospectus

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of (0% i.e. no family discount applicable)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
10	12,682	3	12,682	0	12,682	3	30,705	NA	30,705	3
15	12,682	3	12,682	0	12,682	3		NA		
45	13,795	3	13,795	0	13,795	3		NA		
48	16,910	3	16,910	0	16,910	3		NA		
	56,069				**56,069**				**30,705**	
	Total premium for all members of the family is Rs. 56,069 when each member is covered separately.		Total premium for all members of the family is Rs. 56,069 when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs. 30,705			
	Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate		Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate				Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 8 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 7,000 3. Annual Health Check-Up within specified network - 2 entitlement certificate			

Premium as mentioned above are exclusive of taxes.

Above premium examples are for Illustration purpose only, terms and conditions apply.

Maxima, Policy - Prospectus

Illustration

In-Patient Sum Insured - 3,00,000

Out-Patient Benefits - As mentioned below

Tenure – 1 Year

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of (0% i.e. no family discount applicable)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
35	13,795	3	13,795	0	13,795	3	19,135	NA	19,135	3
40	13,795	3	13,795	0	13,795	3		NA		
	27,590				**27,590**				**19,135**	
	Total premium for all members of the family is Rs. 27,590 when each member is covered separately.		Total premium for all members of the family is Rs. 27,590 when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs.19,135			
	Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate		Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate				Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 6 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,500 3. Annual Health Check-Up within specified network - 2 entitlement certificate			

Premium as mentioned above are exclusive of taxes.

Above premium examples are for Illustration purpose only, terms and conditions apply.

Maxima, Policy - Prospectus

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of (0% i.e. no family discount applicable)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
45	13,795	3	13,795	0	13,795	3	23,585	NA	23,585	3
48	16,910	3	16,910	0	16,910	3		NA		
	30,705				**30,705**				**23,585**	
	Total premium for all members of the family is Rs. 30,705 when each member is covered separately.		Total premium for all members of the family is Rs. 30,705 when they are covered under a single policy.				Total premium when policy is opted on floater basis is Rs. 23,585			
	Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate		Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 4 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,000 3. Annual Health Check-Up within specified network - 1 entitlement certificate				Sum Insured/Benefit available for each individual is: In-Patient - Rs. 3 Lakhs. Out-Patient - 1. 6 Doctor Consultations 2. Diagnostic Tests, Pharmacy, Dental Treatment, Spectacles & Contact Lenses - Rs. 5,500 3. Annual Health Check-Up within specified network - 2 entitlement certificate			

Premium as mentioned above are exclusive of taxes.

Above premium examples are for Illustration purpose only, terms and conditions apply.