HDFC ERGO General Insurance Company Limited

Policy Wordings

OPTIMA RESTORE

HDFC ERGO General Insurance Company Limited will cover all the 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. Definition: Other Important Terms You should know

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

1. Standard Definitions

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

Def. 2. Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was been taken.

Def.3. 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. 4. 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. 5. Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

Def. 6. Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 7. Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position

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

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

Def. 8. Co-payment means a cost-sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Def. 9. Cumulative Bonus (Multiplier Benefit) means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 10. Critical Illness means Cancer of specified severity,

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

i) Cancer of specified severity:

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

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

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

ii) Open Chest CABG:

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

The following are excluded:

- Angioplasty and / or Any other intra-arterial procedures
- Any Key-hole surgery or laser surgery

iii) First Heart Attack of Specified Severity:

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

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

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

The following are excluded:

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

iv) Kidney Failure requiring Regular Dialysis:

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

The diagnosis has to be confirmed by a specialist Medical Practitioner

v) Major Organ/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

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

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

The following are excluded:

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

vi) Multiple Sclerosis with Persisting Symptoms:

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

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

Excluded is:

- Neurological damage due to SLE is excluded.

vii) Permanent Paralysis of Limbs:

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

viii) Stroke resulting in Permanent Symptoms:

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

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

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

The following are excluded:

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

Def. 11. Day Care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

-has qualified nursing staff under its employment;

-has qualified medical practitioner/s in charge;

-has a fully equipped operation theatre of its own where surgical procedures are carried out;

-maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 12. Day Care Procedures means those medical treatment, and/or surgical procedure

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

ii. which would have otherwise required a Hospitalisation of more than 24 hours.

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

Def. 13. Deductible means a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def. 14. Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, filings (where appropriate), crowns, extractions and surgery.

Def. 15. Domiciliary Hospitalisation medical treatment for an illness/disease/injury which in the normal course would require a care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

Def. 16. Disclosure of information norm means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 17. Emergency Care means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Def. 18. Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

Def. 19. 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. 20. Hospitalisation means admission in a Hospital for a minimum of 24 consecutive 'In-patient Care' hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 21. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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 of 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 rehabilitation for the patient or for the patient to be specially trained to cope with it

—it continues indefinitely

—it recurs or is likely to recur

Def. 22. Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 23. 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. 24. 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. 25. 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 intensive charges.

Def. 26. Maternity expenses means

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

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

Def. 27. Medical Advice means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 28. 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. 29. Medically Necessary Treatment 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 ;
- 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. 30. Medical Practitioner means a person who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Def. 31. Migration means the right accorded to individual health insurance policyholders (including all members under family cover and members of group health insurance policy) to transfer the credits gained for pre-existing conditions and time-bound exclusions, with the same insurer.

Def. 32. Network Provider means Hospital enlisted by an insurer or a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility

Def. 33. New Born Baby means baby born during the Policy Period and is aged up to 90 days.

Def. 34. Non Network Provider means any Hospital, day care centre or other provider that is not part of the Network

Def. 35. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 36. OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient

Def. 37. Portability means the right accorded to individual health insurance policyholders (including all members under family cover) to transfer the credits gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

Def. 38. Pre-existing Disease means any condition, ailment, injury or disease:

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

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

Def. 39. 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. 40. 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. 41. Qualified Nurse is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 42. Reasonable & Customary Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 43. Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include associated medical expenses.

Def. 44. 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. 45. 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 from suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 46. Unproven/Experimental treatment means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

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

Def. 4. Alternative treatments means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Def. 5. Bank Rate means 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. Contribution means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def. 8. Dependents means only the family members listed below:

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

ii) Your children Aged between 91 days and 25 years if they are unmarried

iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Optima Restore Policy.

iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Optima Restore Policy.

All Dependent parents must be financially dependent on You.

Def. 9. Dependent Child means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 10. Insured Person means You and the persons named in the Schedule.

Def. 11. Family Floater means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or

all of Your Dependents during the Policy Period.

Def. 12. Material Facts means 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. 13. Policy means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure 1 and the policy schedule (as the same may be amended from time to time).

Def. 14. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 15. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 16. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 17. We/Our/Us means the HDFC ERGO General Insurance Company Limited

Def. 18. You/Your/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

1. In-patient Benefits

This section of benefits is applicable when

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

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

We will cover the Medical Expenses for:	**In addition to the waiting periods (Section C1) and general exclusions (Section C2&C3), We will also not cover expenses**
a. In-patient Treatment. This includes • Hospital room rent or boarding; • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anaesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures. 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.	If as per any or all of the Medical references herein below containing guidelines and protocols for Evidence Based Medicines, the Hospitalisation for treatment under claim is not necessary or the stay at the hospital is found unduly long: • Medical text books, • Standard treatment guidelines as stated in clinical establishment act of Government of India, • World Health Organisation (WHO) protocols, • Published guidelines by healthcare providers, • Guidelines set by medical societies like cardiological society of India, neurological society of India etc.
b. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital (In-patient OR Day Care OR Domiciliary treatment).	i) Claims which have NOT been admitted under 1 a) and 1d). ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
c. Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 180 days after discharge from the Hospital (In-patient OR Day Care OR Domiciliary treatment).	i) Claims which have NOT been admitted under 1 a) and 1d). ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
d. Day Care Procedures Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours	i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) Treatment NOT taken at a Hospital or Day-care centre.
Treatment normally taken on out-patient basis is not included in the scope of this definition.	

e. Domiciliary Treatment Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii. The patient takes treatment at home on account of non availability of room in a Hospital. Pre and Post Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation and 180 days after hospitalization respectively will be covered in case of domiciliary treatment.	1. Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days only if treatment period is greater than three days).
f. Organ Donor: Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an insured person while donating an organ is NOT covered.	1. Claims which have NOT been admitted under 1a) for insured member. 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
g. Ambulance Cover Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under Section 1a) and Section 1d). 2. Healthcare or ambulance service provider not registered with road traffic authority.
h. Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as mentioned in schedule of benefits if the Insured Person is hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.	1. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 2. Claims which have NOT been admitted under 1a).
i. E-Opinion in respect of a Critical Illness We shall arrange and pay for a second opinion from Our panel of medical Practitioners, if: -The Insured Person suffers a Critical Illness during the Policy Period; and -He requests an E-opinion; and The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner. "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke.	1. More than one claim for this benefit in a Policy Year. 2. 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
j. Emergency Air Ambulance Cover We will pay for ambulance transportation in an airplane or helicopter subject to maximum limit prescribed in j (1) , for emergency life threatening health conditions which require immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide subject to: • Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency; • The Medical Evacuation been prescribed by a Medical Practitioner and is Medically Necessary;	1. Claims which have NOT been admitted under 1 a) and 1d). 2. Expenses incurred in return transportation to the insured's home by air ambulance is excluded

• The insured person is in India and the treatment is required in India only and not overseas in any condition whatsoever; and • The air ambulance provider being registered in India. J(i) The amount payable in case of Air ambulance facility shall be either the actual expenses or Rs. 2.5 Lacs per hospitalisation, whichever is lower; upto basic sum insured limit for a year.	

Important terms You should know.

Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. And is NOT a member of the Insured Person's family or stays with him.

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

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

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, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Period.

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.

Out-patient Treatment means the medical consultation, investigations or treatment taken in a clinic / hospital or associated facility like a consultation room. Important to note that out-patient treatment does not require admission to day care or in-patient sections of hospital.

2. a. Restore Benefit

Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Multiplier Benefit (if applicable) during the Policy Year. The Total amount (Basic sum insured, Multiplier benefit and Restore sum insured) will be available to all Insured Persons for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Multiplier Benefit (if applicable).Conditions for Restore benefit:

i. The Sum Insured will be restored only once in a Policy Year.

ii. If the Restored Sum Insured is not utilized in a Policy Year, it will expire.

In case of a Family Floater Policy, Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

b. Unlimited Restore Benefit (Optional benefit)

This optional cover will be provide instant addition of 100% Basic Sum Insured on complete or partial utilization of Your Restore benefit or Unlimited Restore benefit (as applicable) during the Policy Year. This optional cover will trigger unlimited times and is available for all subsequent claims in a Policy Year.

Conditions for Unlimited Restore benefit:

i. The Sum Insured will be restored under this optional cover for the subsequent claim in the Policy Year.

ii. A single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Multiplier Benefit (if applicable).

In case of a Family Floater Policy, Unlimited Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

Illustration of Sum Insured utilization in a Policy Year

Basic Sum Insured : 5 Lacs

Multiplier Benefit: 2.5 Lacs

Number of Claim	Claim amount	Available Benefit Limit				Admissible claim amount	Utilization of Sum Insured
		Basic Sum Insured	Multiplier Benefit	Restore Benefit	Unlimited Restore Benefit		
1st claim	7,00,000	5,00,000	2,50,000	0	0	7,00,000	Basic + Multiplier (Partial)
2nd claim	3,50,000	-	50,000	5,00,000	0	3,50,000	Multiplier (balance) + Restore (partial)
3rd claim	3,00,000	-	-	2,00,000	5,00,000	3,00,000	Restore (balance) + Unlimited Restore
4th claim	7,00,000	-	-	-	5,00,000	5,00,000	Unlimited Restore
5th claim	5,00,000	-	-	-	5,00,000	5,00,000	Unlimited Restore

3. Preventive Health Check-up

This benefit is effective only if mentioned in the schedule of benefits.

a) If You have maintained an Optima Restore Policy with Us for the period of time mentioned in the schedule of benefits without any break, then at the end of each block of continuous years (as mentioned in the schedule of benefits) We will pay upto the amount mentioned in the Schedule of Benefits towards the cost of a preventive health check-up for those Insured Persons who were insured for the number of previous Policy Years mentioned in the Schedule.

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

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

Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Plan	3 Lacs	5 Lacs	10 Lacs	15 Lacs	20,25,50, 100 Lacs
Optima Restore Individual	Not Applicable	Upto a maximum of Rs.1,500 per insured person, only once at the end of a block of every continuous two Policy Years.	Upto a maximum of Rs.2,000 per insured person at the end of each year at renewal.	Upto a maximum of Rs.4,000 per insured person, at the end of each year at renewal	Upto Maximum of Rs. 5,000 per Insured Person, at the end of each year at renewal
Optima Restore Family	Not Applicable	Upto a maximum of Rs.2,500 per policy, only once at the end of a block of every continuous two Policy Years.	Upto a maximum of Rs.5,000 per policy at the end of each year at renewal	Upto a maximum of Rs.8,000 per policy, at the end of each year at renewal.	Upto Maximum of Rs. 10,000 per policy, at the end of each year at renewal.

4. Multiplier Benefit

a) If NO claims have been made in respect of any benefit listed under Section 1 in a Policy Year and the Policy is renewed with Us without any break

i) We will apply a bonus by enhancing the renewed policy's Sum Insured by 50% of the Basic Sum Insured of the previous year's Policy.

ii) The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

In Family Floater policy,

1. The Multiplier Benefit shall be available on Family Floater basis and accrue only if no claims have been made in respect of any Insured Person during the previous Policy Year.

2. Accrued Multiplier Benefit is available to all Insured Persons under the Policy.

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

c) If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the multiplier bonus for each member in the expiring policy, and such expiring

policy is renewed with Us on a Family Floater basis, then the multiplier bonus to be carried forward for credit in the Policy would be the lowest accrued multiplier bonus amongst all the Insured Persons from the expiring Policy.

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

e) In policies with a 2/3 year Policy Period, the application of above guidelines of Multiplier Benefit shall be post completion of each policy year.

Section C. Special terms and conditions

1. Standard Waiting Periods

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

i. 30-day waiting period – Code – Excl03

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

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

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

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

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

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

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

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

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

f) List of specific diseases/procedures: -

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

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

iii. Pre-Existing Diseases – Code – Excl01

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

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

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

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

2. Standard Exclusions

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

Non Medical Exclusions	1.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. 2.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	3.Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof – Code – Excl12 4.Obesity/ Weight Control: Code – Excl06 Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: i. Surgery to be conducted is upon the advice of the Doctor ii. The surgery/Procedure conducted should be supported by clinical protocols iii. The member has to be 18 years of age or older and iv. Body Mass Index (BMI); a) greater than or equal to 40 or b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: i. Obesity-related cardiomyopathy ii. Coronary heart disease iii. Severe Sleep Apnoea iv. Uncontrolled Type2 Diabetes 5.Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. Code –Excl15

	6. 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. 7. 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. 8. 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 9. Investigation & Evaluation: Code – Excl04 a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded. b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded. 10. Rest Cure, rehabilitation and respite care: Code – Excl05 a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.This also includes: i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons. ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs. 11. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code – Excl13 12. 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 13. Maternity: Code – Excl18 i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period. 14. Sterility and Infertility: Code – Excl17 Expenses related to sterility and infertility. This includes: i. Any type of contraception, sterilization ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI iii. Gestational Surrogacy iv. Reversal of sterilization 15. 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.

3. Specific Exclusions

Non Medical Exclusions	1. War or similar situations- Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. 2. Intentional self-injury or attempted suicide. 3. Any Insured Person's participation or involvement in naval, military or air force operation.

Medical Exclusions	4. Prosthetic and other devices which are self-detachable /removable without surgery involving anaesthesia 5. Treatment availed outside India 6. Treatment at a healthcare facility which is NOT a Hospital. 7. Circumcisions (unless necessitated by Illness or injury and forming part of treatment) 8. Any non allopathic treatment except to the extent of coverage provided for under 'In-patient Hospitalization treatment' cover. 9. Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation. 10. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); 11. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products. 12. Sleep-apnoea 13. External congenital diseases, defects or anomalies 14. The expense incurred by the insured on organ donation. 15. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. 16. Any non-medical expenses mentioned in List – I of Annexure I. 17. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. 18. 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. 19. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. 20. Drugs or treatments which are not supported by a prescription. 21. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured. 22. Admission for administration of Intra-articular or Intra-lesional injections, Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc) or IV immunoglobulin infusion 23. Dental treatment and surgery of any kind, unless requiring Hospitalisation.

Section D. General Terms and Clauses

1. Standard General Terms and Clauses

a. Condition 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. Claim Settlement (Provision for Penal Interest)

i) 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.

ii) 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.

iii) 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.

iv) 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.

v) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We have 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.

vi) We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule), payments under this Policy shall only be made in Indian Rupees within India.

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

viii) 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.

ix) Cashless service: If any treatment, consultation or

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

x) In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.

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

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

c. 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 have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

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

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

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

c) any other act fitted to deceive; and

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

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

d. 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 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 thisPolicy.

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.

d. Renewal of Policy

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.

d. 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. to require a 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

Up to 6 month	45.0%	70.0%	80.0%
Up to 12 month	0.0%	45.0%	65.0%
Up to 15 month	Not Applicable	30.0%	55.0%
Up to 18 month	Not Applicable	20.0%	45.0%
Up to 24 month	Not Applicable	0.0%	30.0%
Up to 27 month	Not Applicable	Not Applicable	20.0%
Up to 30 month	Not Applicable	Not Applicable	15.0%
Up to 36 month	Not Applicable	Not Applicable	0.0%

For Policies where premium is paid by instalment, the following additional conditions will be applicable:

i. Where yearly payment option is in force under the Policy, cancellation grid as per 1-Year Tenure policies will be applicable.

ii. For all other payment options, 50% of current instalment premium will be refunded when the current period elapsed is less than 6 months from the commencement of the Policy Year. For instalment after 6 months, no refund will be payable.

iii. In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

- 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.

h. Free Look Period

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

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

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

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

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

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

i. 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.

j. 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.

k. 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

l. 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

m. 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

n. 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.

o. Withdrawal of Policy

a. 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.

b. 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.

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. Premium Payment in Instalments

If the Insured Person has opted for payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

i. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy

Options	Instalment Premium Option	Grace Period applicable
Option 1	Multi-Year / Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 Days

ii. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company

iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period

iv. No interest will be charged If the installment premium is not paid on due date

v. In case of installment premium due not received within the Grace Period, the Policy will get cancelled

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable

vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

Instalment premium payment through Auto Debit/ ECS Facility

i. If Option of Premium payment by instalment is opted through auto Debit/ECS facility, Electronic Clearing Service (ECS) Mandate form needs to be completely filled & signed by the Insured Person.

ii. The Premium amount which would be auto debited & frequency of instalment should be duly filled in the ECS Mandate form.

iii. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.

iv. The Company should be informed at least 15 days prior to the due date of instalment premium if the Insured Person wishes to discontinue the ECS facility.

v. Non-payment of premium on due date as opted by the Insured Person in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the Policy.

i. Redressal of Grievances

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

2. Specific Terms and 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. For the purpose of policy issuance, the premium will be computed basis the city of residence provided by the insured person in the proposal form. The premium that would be applicable zone wise and the cities defined in each zone are as under:

- Tier 1 : Delhi, NCR, Mumbai, Thane, Mumbai Suburban and Navi Mumbai, Surat, Ahmedabad & Vadodara
- Tier 2 : Rest of India- All other cities
- The premium will be modified in case of mid term address change involving migration from one zone to another and would be calculated on pro-rata basis.

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.

Any Insured Person in the policy has the option to migrate to similar indemnity health insurance policy available with us at the time of renewal subject to underwriting with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability/migration guidelines.

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

c. Loadings & Discounts

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

We will inform You about the applicable risk loading or exclusion or both as the case may be through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days. We will issue Policy only after getting Your consent and additional premium (if any). Please visit our nearest branch to refer our underwriting guidelines if required.

- Online Discount: The Insured Person is eligible for 5% discount on premium in case he / she purchase the Policy online from the Company's website or the Company's mobile app. The subsequent Renewal of the same Policy will continue to enjoy the 5% discount, provided the Policy remains without the involvement of any other insurance agent or insurance intermediary.
- Employee Discount: A discount of 5 % on the Premium is

applicable if any Insured Person is a HDFC Group employee (full time employee) / Munich Re Group employee (full time employee) at the time of enrolment, or subsequent renewal; provided that such Policy is purchased through the Company's website or the Company's mobile app and without the involvement of any insurance agent or insurance intermediary.

- Loyalty Discount: If any Insured Person has an active retail insurance Policy with premium above Rs. 2,000 with the Company, a discount of 2.5% on the Policy premium will be applicable at the time of enrolment as well as subsequent renewals.

- Family Discount: The Insured Person will be entitled to receive 10% discount on the premium if two or more family members are covered under the same Policy under the individual Policy option.

The above mentioned discounts are cumulative in nature and the total discount offered under Employee discount, Online discount, Loyalty discount and Family discount shall not exceed 20%.

- Long Term Policy Discount: If the Policy Period is more than one year, the Insured Person will be entitled to receive a discount of 7.5% and 10% will be offered in case a Policy is purchased for 2-year and 3-year tenure respectively, provided he has paid the premium in advance as a single premium.

PI Note:

The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section C.1 i),ii) & iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

Stay Active

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

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

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

The discount grid would be as per the table below:

1 Year Policy

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

2 Year Policy

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

3 Year Policy

Time Interval (calculated from policy risk start date)						
Average Step target	**Risk start date or date of download of mobile application -90 days**	**91-180 days**	**181-270 days**	**271-360 days**	**361-450 days**	**451-540 days**
5000 or below	0%	0%	0%	0%	0%	0%
5001 to 8000	0.1667%	0.1667%	0.1667%	0.1667%	0.1667%	0.1667%
8001 to 10000	0.41667%	0.41667%	0.41667%	0.41667%	0.41667%	0.41667%
Above 10000	0.6667%	0.6667%	0.6667%	0.6667%	0.6667%	0.6667%

Time Interval (calculated from policy risk start date)						
541-630 days	631-720 days	721-810 days	811-900 days	901-990 days	991-1020 days	Maximum Discount at the end of 3 years
0%	0%	0%	0%	0%	0%	0%
0.1667%	0.1667%	0.1667%	0.1667%	0.1667%	0.1667%	2%
0.41667%	0.41667%	0.41667%	0.41667%	0.41667%	0.41667%	5%
0.6667%	0.6667%	0.6667%	0.6667%	0.6667%	0.6667%	8%

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

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

Illustration

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

Total discount applicable on renewal premium = 3.5%

d. Notification of Claim

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

e. Cashless Service:

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

f. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information We may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include but is not limited to the following:

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

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

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

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

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

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

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

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

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

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

xi) Stickers and invoice of implants used during surgery

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

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

xiv) Legal heir certificate

g. The Insured Person shall 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.

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 rejected/ repudiated forthwith.

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.

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. 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.

k. 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/ entity is authorised to receive any notice on Our behalf.

Section E. Other Terms & Conditions

Contact Us

	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

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

Ombudsman Details

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.
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.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
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

This Policy is subject to regulation 12 of IRDAI (Protection of Policyholder's Interests) Regulations 2017.

Annexure I – List of Non-Medical Expenses

S. No.	Item	S. 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

List II–Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III–Items that are to be subsumed into Procedure Charges

Sl No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT

8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV–Items that are to be subsumed into costs of treatment

Sl No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG

Schedule of benefits

Optima Restore Individual

Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00	5.00	10.00	15.00	20.00, 25.00, 50.00, 100.00
1a) In-patient Treatment	Covered	Covered	Covered	Covered	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 Days	Covered, upto 180 Days	Covered, upto 180 Days	Covered, upto 180 Days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered	Covered	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered	Covered	Covered	Covered
1f) Organ Donor	Covered	Covered	Covered	Covered	Covered
1g) Ambulance Cover	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation
1h) Daily Cash for choosing Shared Accommodation	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered	Covered	Covered	Covered
1j) Emergency Air Ambulance Cover	Not Covered	Not Covered	Covered	Covered	Covered
2) a) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
2) b) Unlimited Restore Benefit (Optional Benefit)	Applicable if opted	Applicable if opted	Applicable if opted	Applicable if opted	Applicable if opted
3) Preventive Health Checkup (per person)	Not Applicable	Upto Rs 1500	Upto Rs. 2000	Upto Rs. 4000	Upto Rs. 5000
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal

Optima Restore Family

Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00	5.00	10.00	15.00	20.00, 25.00, 50.00, 100.00
1a) In-patient Treatment	Covered	Covered	Covered	Covered	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 Days	Covered, upto 180 Days	Covered, upto 180 Days	Covered, upto 180 Days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered	Covered	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered	Covered	Covered	Covered
1f) Organ Donor	Covered	Covered	Covered	Covered	Covered
1g) Ambulance Cover	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation
1h) Daily Cash for choosing Shared Accommodation	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered	Covered	Covered	Covered
1j) Emergency Air Ambulance Cover	Not Covered	Not Covered	Covered	Covered	Covered
2) a) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
2) b) Unlimited Restore Benefit (Optional Benefit)	Applicable if opted	Applicable if opted	Applicable if opted	Applicable if opted	Applicable if opted
3) Preventive Health Checkup (per policy)	Not Applicable	Upto Rs 2500	Upto Rs.5000	Upto Rs. 8000	Upto Rs. 10,000
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal

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