**OPTIMA PLUS - POLICY WORDINGS**




HDFC ERGO General Insurance Company Limited. IRDAI Reg. No. 146. CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. UIN - HDHHLIP21336V022021

Preamble

HDFC ERGO General Insurance Company Limited will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the terms and conditions of this Policy, Your payment of premium, and Your statements in the Proposal, which is incorporated into the Policy and is the basis of it.

## Section A. Definitions

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

### *I. Standard Definition*

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

Def. 2. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
**iii.** Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 3. **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;


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

Def. 4. **Any One Illness** means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/nursing home where trea**tmen**t **may h**ave been taken. Occurrence of same illness after a l**a**pse of 45 days as stated above will be considered as fresh illness for the purpose of this Policy.

Def. 5. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position

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

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

Def. 6. **Day care treatment** means medical treatment, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hrs because of technological advancement, and which would have otherwise required a Hospitalization of more than 24 hours, but treatment normally taken on an out-patient basis is not included in the scope of this definition.

Def. 7. **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 (as mention in Policy Schedule) of the covered expenses, which will apply before any benefits are payable by the insurer. A Deductible does not reduce the Sum Insured.

Def. 8. **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. 9. **Emergency** or **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 Practition**e**r to prevent death or serious long term impairment of the Insured Person's health.

Def. 10. **Grace Period** specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period(Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def. 11. **Hospital** means any institution in India established for inpatient care and Day care treatment of sickness and/or injuries and which has been registered as a Hospital 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:

i. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places

ii. has qualified nursing staff under its employment round the clock
iii. has qualified medical practitioner (s) in charge round the clock
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out.
**v.** maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 12. **Hospitalization** means admission in a **Hospital** for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 13. **Illness/ Illnesses**means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

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

(b) Chronic condition - A chronic condition is defined as a disease, **Illness**, or **Injury** that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Def. 14. **Inpatient** or **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 15. **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. 16. **Maternity Expenses** means:

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during **Hospitalization**).
ii. Expenses towards lawful medical termination of pregnancy during the policy Period.

Def. 17. **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 Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 18. **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.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 1. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 19. **Non Network** means any Hospital, day care centre or other provider that is not part of the network.

Def. 20. **Pre-existing Condition** means any condition, ailment, injury, or disease:

(b) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

(c) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def. 21. **Portability Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer**Pre-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined 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 **Hospitalization** was required, and

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

Def. 22. **Post-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined 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. 23. **Reasonable and 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. 24. **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


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and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 25. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

### *II. Specific Definitions*

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

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

Def. 3. **AYUSH Treatment** refers to medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 4. **Bank Rate** shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 5. **Break in policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period

Def. 6.

Def. 7. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

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

i) Your legally married spouse as long as he/she continues to be married to You;
ii) Your children Aged between 91 days and 21 years if they are unmarried.
iii) Your natural parents or parents that have legally adopted You, provided that:
   a) The parent was below 65 years at his initial participation in the Optima Plus Policy, and
   **b)** Parents shall not include Your spouse's parents.

Def. 9. **Dependent Child** means a child (natural or legally adopted), who is financially dependent on You 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. **Material Facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 12. **Non Installment Premium Payment refers to payment of premium for the entire policy period made in advance as a single premium.**

Def. 13.

Def. 14. **Policy** means Your statements in the proposal form, this policy wording (including endorsements, if any)and the Schedule (as the same may be amended from time to time).

Def. 15. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 16. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 17. **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.

Def. 18. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 19. **We/Our/Us** means the HDFC ERGO General Insurance Limited

Def. 20. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

## Section B. Benefits

Claims made in respect of any of the benefits below will be subject to the Sum Insured.

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's Hospitalisation as an Inpatient, then We will pay for the Medical Expenses for the benefits mentioned below, in excess of the Deductible stated in the Schedule.

Our maximum liability for a continuous period of Illness, including relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Schedule of Benefits. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

a) **In-patient Treatment**

The Medical Expenses for:

i) Room rent, boarding expenses,
ii) Nursing,
iii) Intensive care unit,
iv) Medical Practitioner(s),
v) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
vi) Medicines, drugs and consumables,
vii) Diagnostic procedures,
viii) The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

<u>Note pertaining specifically to AYUSH Treatments only:</u>

Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient treatment' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this policy.


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b) **Pre-Hospitalisation Medical Expenses**

The Medical Expenses incurred in the 60 days immediately before the Insured Person was Hospitalised, provided that:

i) Such Medical Expenses were in fact incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
ii) We have accepted an inpatient Hospitalisation claim under Benefit Ba).

c) **Post-hospitalisation Medical Expenses**

The Medical Expenses incurred in the 90 days immediately after the Insured Person was discharged post Hospitalisation provided that:

i) Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalisation was required, and
ii) We have accepted an inpatient Hospitalisation claim under Benefit Ba).

d) **Day Care Procedures**

The Medical Expenses for a day care procedure where the procedure or surgery is under taken under General or Local Anaesthesia in a **Hospital**/**Day Care Centre** in less than 24 hours because of technological advancement, and which would have otherwise required **Hospitalization** of more than 24 hours. Treatment normally taken on an Out-patient basis is not included in the scope of this cover

e) **Organ Donor**

The Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

i) The organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended) and
ii) The organ donated is for the use of the Insured Person, and
iii) We will not pay the donor's pre and post-Medical Expenses or any other medical treatment for the donor consequent on the harvesting, and
iv) We have accepted an inpatient Hospitalisation claim under Benefit Ba).

f) **Emergency Ambulance**

We will reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate Emergency facilities for the provision of health services following an Emergency, provided that:

i) Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and
ii) We have accepted an inpatient Hospitalisation claim under Benefit Ba).
iii) The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and

provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, provided that transportation has been prescribed by a Medical Practitioner and is medically necessary.

**g) Domiciliary Treatment**

The Medical Expenses incurred by an Insured Person for medical treatment taken at his home which would otherwise have required Hospitalisation because, on the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or a Hospital bed was unavailable, and provided that:

i) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period, and

## Section C. Waiting Period & Exclusions

### *I. Standard Waiting Period*

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

**i. 30-day Waiting Period: Code – Excl03**

I. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
II. This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.
III. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

I. Expenses related to the treatment of the listed Conditions, surgeries/treatments as mentioned in the table below shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident**.
II. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of **Sum Insured** increase.
III. If any of the specified disease/procedure falls under the waiting period specified for **Pre-existing diseases**, then the longer of the two waiting periods shall apply.
IV. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.


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V. If the **Insured Person** is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
VI. List of specific diseases/procedure:

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

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

**iii. P re- Existing Diseases: Code- Excl01**

i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

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

## *II. Standard Permanent Exclusions*

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

i. **Investigation & Evaluation: Code – Excl04**
   a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
   **b.** Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

ii. **Rest Cure, rehabilitation and respite care: Code – Excl05** – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   **b.** Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. **Obesity/Weight control: Code – Excl06** – Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the doctor
   b. The surgery/procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI)
      i. Greater than or equal to 40 or,
      ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         1. Obesity related cardiomyopathy
         2. coronary heart disease
         3. severe sleep apnoea
         **4.** uncontrolled type2 diabetes

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

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

vi. **Hazardous or Adventure sports: Code – Excl09** – Expenses related to any treatment necessitated due to participation as a professional in **Hazardous** or **Adventure sports**, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

vii. **Breach of Law: Code – Excl10 -** Expenses for treatment directly arising from or consequent upon any **Insured Person** committing or attempting to commit a breach of law with criminal intent.

viii. **Excluded Providers: Code11 -** Expenses incurred towards treatment in any hospital or by any **Medical Practitioner** or any other provider specifically excluded by the **Insurer** and disclosed in its website/notified to the policyholders are not admissible. However, in case of **life threatening situations** or following an **Accident,** expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

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

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

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

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
**d.** Reversal of sterilization

xv. **Maternity: Code – Excl18**

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy** period.

### *IV. Specific Permanent Exclusions*

i. War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence,

rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

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

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

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

v. Congenital external diseases, defects or anomalies,

vi. Stem cell harvesting

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

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

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

x. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

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

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

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

xiv. Treatment taken on Outpatient basis

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

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

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

xviii. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs crutches and oxygen concentrator for bronchial asthma/ COPD


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conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses attached and also available on www.hdfcergo.com.

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

xx. Dental treatment and surgery of any kind, unless requiring Hospitalisation

xxi. Any non-allopathic treatment except to the extent of coverage provided for under 'In-patient treatment' cover.

xxii. Any exclusion mentioned in the Schedule or the breach of any specific condition mentioned in the Schedule

## Section D. General Terms & Clauses

### *I. Standard General Terms & 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)**

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a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the bank rate.

**c. 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.

**d. Fraud**

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that


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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.

e. **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 thirtydays 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;

**f. Multiple Policies**

**i.** In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

**ii.** Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

**iii.** If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

**iv.** Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

**g. Renewal of Policy**

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to conditions stated under Moratorium clause of this schedule.

a) Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.
b) The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
c) No loading shall apply on renewals based on individual claims experience

d) The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.

e) Renewal premium due can be paid prior to the due date as per norms set out by the Company

**h. Withdrawal of Policy**

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

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

**i. 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.

**j. 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.**Cancellation**

i. The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period. Note : For Policies where premium is paid by instalment : 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.

ii. The Company may cancel the Policy at any time on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud or non-disclosure or misrepresentation.

iii. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s

**iv.** Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or any benefit has been availed by the Insured Person under the Policy

**i.**

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**ii.**

**k. Moratorium Period**

l. After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced

m.

**n. 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 30 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.

**o. 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.

**p. 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.

**q. 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**.

**r. Grievance Redressal Procedure**

In case of any grievance the insured person may contact the company through:

- Website: www.hdfcergo.com


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- Contact No: 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 - seniorcitizen@hdfcergo.com | https://www.hdfcergo.com/ customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com | https:// www.hdfcergo.com/ customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com |
| Write to us at | care@hdfcergo.com | grievance@hdfcergo.com | cgo@hdfcergo.com |
| | Grievance cell of any of our Branch office | The Grievance Cell, HDFC ERGO General Insurance Company Ltd 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059 | The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020 |

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://igms.irda.gov.in/

### *II. Specific General Terms*

a. **Insured Person**

Only those persons named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.
There is no maximum cover ceasing age under this Policy.

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.

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

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

**b. Notification of Claim**

| | **Treatment, Consultation or Procedure:** | **We or Our TPA must be informed:** |
|---|---|---|
| **1)** | 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. |
| 2) | 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. |
| 3) | For all benefits which are contingent on Our prior acceptance of a claim under | Within 7 days of the Insured Person's discharge post-hospitalisation. |

| | | |
|---|---|---|
| | Section 1)a): | |
| 4) | If any treatment, consultation or procedure for which a claim may be made is required in an Emergency: | Within 7 days of completion of such treatment, consultation or procedure. |
| 5) | In all other cases: | Of any event or occurrence that may give rise to a claim under this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorise such treatment, consultation or procedure. |

Note: In the case of a covered Hospitalisation, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with a copy of intimation made to the other insurer /Reimbursement Provider immediately on knowing that the Deductible is likely to be exceeded.

c. **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:** |
|---|---|---|---|---|
| **1)** | 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 |
| 2) | If any treatment, consultation or procedure for which a claim may be made is 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 |

**d. Supporting Documentation & Examination**

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

ii) Our claim form, duly completed and signed for on behalf of the Insured Person.
iii) 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.
iv) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
v) A precise diagnosis of the treatment for which a claim is made.
vi) A detailed list of the individual medical services and treatments provided and a unit price for each.
vii) 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.

Note:
i) When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.
ii) If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

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.

**e. Claims Payment**

- 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 or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

- Our liability to make payment under this policy will only begin when the Deductible as mentioned in Schedule is exceeded. We will pay to the Insured Person, Medical Expenses over and above Deductible but not exceeding the Sum Insured for the Policy Period.

- We will only make payment to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be

deemed to be authorised by You to receive the concerned payment. In the event of the death of You or an Insured Person, We will make payment to the Nominee (as named in the Schedule). The assignment of benefits payable under this Policy shall be subject to applicable law.

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

- This Policy only covers medical treatment taken within India, and payments under this Policy shall only be made in Indian Rupees within India.

- 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.

**f. Alterations to the Policy**

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

**g. Change of Policyholder**

The change of Policyholder (except clause w) is permitted only at the time of renewal. If You do not renew the Policy, the other Insured Persons may apply to renew the Policy subject to condition p) above. However, in case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court subject to condition p) above.

**h. Notices**

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

i) Any Insured Person, then it shall be sent to You at Your address specified in the Schedule and You shall act for all Insured Persons for these purposes.

ii) Us, it shall be delivered to Our address specified in the Schedule. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.


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**i. Dispute Resolution Clause**

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

**j. Waiver of Deductible**

We will offer the Insured Person an option to waive the deductible and to opt for 5 Lacs indemnity health insurance Policy (without any Deductible) with Us provided that:

i) Insured Person has been insured with Us for first time under this Policy before the age of 50 years and has renewed with us continuously and without any interruption,

ii) This option for waiver of deductible shall be exercised by the Insured Person only during the age group of 58 to 60 years, and certainly at the time of renewal only.

iii) Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy.

In all other cases, No benefits shall accrue to any Insured Person by virtue of continuity of coverage in the event of discontinuation of this Policy at any point of time or shifting to any other Health Insurance Policy with Us.

**k. 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:

i. 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

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

l. 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;

i. Permanently exclude the disease/condition and continue with the Policy

ii. Incorporate additional waiting period of not exceeding3years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

iii. 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.

## Section E. Other Terms & Conditions

### *I. Deductible*

We are not liable for any payment unless the Medical Expenses exceed the Deductible. Deductible shall be applicable for each and every Hospitalisation except claims made for Any One Illness.

### *II. Claim Related Information*

| | **Within India** | **Outside India** |
|---|---|---|
| **Claim Intimation:** | **Contact No**:022 6234 6234 / 0120 6234 6234<br><br>**Phone (UAN)** :1860 2000 700 ( Local charges applicable )<br>**Fax (UAN)** : 1860 2000 600 ( Local charges applicable )<br>**Email**:healthclaims@hdfcergo.com | **Global ContactNo** : +800 08250825 (accessible from locations outside India only)<br>**Landline no (Chargeable)** : 0120-4507250<br>**Email**travelclaims@hdfcergo.com |
| **Claim document submission at address** | HDFC ERGO General Insurance Co. Ltd.<br>Stellar IT Park, Tower-1<br>5th Floor, C - 25, Sector 62<br>Noida – 0120 398 8360 | HDFC ERGO General Insurance Co Ltd<br>6th Floor, Leela Business Park,<br>AndheriKurla Road, Andheri East,<br>Mumbai-400059,<br>Ph-022 66383600 |

Note - The Policyholder(s) shall have right to exercise an option to change the existing TPA within 30 days prior to the date of renewal of the Policy from the list of our empanelled TPAs for serving and process claim under the Optima Plus Policy.


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## List of Ombudsman

| S.No | Office Details | Jurisdiction of Office (Union Territory,District) |
|---|---|---|
| 1 | **AHMEDABAD**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Jeevan Prakash Building, 6th floor,<br>Tilak Marg, Relief Road,<br>AHMEDABAD – 380 001.<br>Tel.: 079 - 25501201/02<br>Email: bimalokpal.ahmedabad@cioins.co.in | Gujarat, Dadra & Nagar Haveli, Daman and Diu. |
| 2 | **BENGALURU**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Jeevan Soudha Building,PID No. 57-27-N-19<br>Ground Floor, 19/19, 24th Main Road,<br>JP Nagar, Ist Phase, Bengaluru – 560 078.<br>Tel.: 080 - 26652048 / 26652049<br>Email: bimalokpal.bengaluru@cioins.co.in | Karnataka. |
| 3 | **BHOPAL**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>1st floor,"Jeevan Shikha",<br>60-B,Hoshangabad Road, Opp. Gayatri Mandir,<br>Bhopal – 462 011.<br>Tel.: 0755 - 2769201 / 2769202:<br><br>Email : bimalokpal.bhopal@cioins.co.in | Madhya Pradesh, Chhattisgarh. |
| 4 | **BHUBANESWAR**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>62, Forest park,<br>Bhubaneswar – 751 009.<br>Tel.: 0674 - 2596461 /2596455<br>Email: bimalokpal.bhubaneswar@cioins.co.in | Odisha. |
| 5 | **CHANDIGARH**<br>Insurance Ombudsman<br>Office Of The Insurance Ombudsman,<br>Jeevan Deep Building SCO 20-27,<br>Ground Floor Sector- 17 A,<br>Chandigarh – 160 017.<br>Tel.: 0172-2706468<br>Email: bimalokpal.chandigarh@cioins.co.in | Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh. |

| | | |
|---|---|---|
| 6 | **CHENNAI**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Fatima Akhtar Court, 4th Floor, 453,<br>Anna Salai, Teynampet,<br>CHENNAI – 600 018.<br>Tel.: 044 - 24333668 / 24333678<br>Email: bimalokpal.chennai@cioins.co.in | Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry). |
| 7 | **DELHI**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>2/2 A, Universal Insurance Building,<br>Asaf Ali Road,<br>New Delhi – 110 002.<br>Tel.: 011 - 23237539<br>Email: bimalokpal.delhi@cioins.co.in | Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh. |
| 8 | **GUWAHATI**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Jeevan Nivesh, 5th Floor,<br>Nr. Panbazar over bridge, S.S. Road,<br>Guwahati – 781001(ASSAM).<br>Tel.: 0361 - 2632204 / 2602205<br>Email: bimalokpal.guwahati@cioins.co.in | Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. |
| 9 | **HYDERABAD**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>6-2-46, 1st floor, "Moin Court",<br>Lane Opp. Saleem Function Palace,<br>A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.<br>Tel.: 040 - 23312122<br>Email: bimalokpal.hyderabad@cioins.co.in | Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry. |
| 10 | **JAIPUR**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Jeevan Nidhi – II Bldg., Gr. Floor,<br>Bhawani Singh Marg,<br>Jaipur - 302 005.<br>Tel.: 0141- 2740363/2740798<br>Email: bimalokpal.jaipur@cioins.co.in | Rajasthan. |


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| 11 | **KOCHI**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>10th Floor, Jeevan Prakash,LIC Building,<br>Opp to Maharaja's College Ground,M.G.Road,<br>Kochi - 682 011.<br>Tel.: 0484 - 2358759<br>Email: bimalokpal.ernakulam@cioins.co.in | Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. |
| 12 | **KOLKATA**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Hindustan Bldg. Annexe, 7th Floor,<br>4, C.R. Avenue,<br>KOLKATA - 700 072.<br>Tel.: 033 - 22124339 / 22124341<br>Email: bimalokpal.kolkata@cioins.co.in | West Bengal, Sikkim, Andaman & Nicobar Islands. |
| 13 | **LUCKNOW**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>6th Floor, Jeevan Bhawan, Phase-II,<br>Nawal Kishore Road, Hazratganj,<br>Lucknow - 226 001.<br>Tel.: 0522 - 4002082 / 3500613<br>Email: bimalokpal.lucknow@cioins.co.in | Districts of Uttar Pradesh : Lalitpur, 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. |
| 14 | **MUMBAI**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>3rd Floor, Jeevan Seva Annexe,<br>S. V. Road, Santacruz (W),<br>Mumbai - 400 054.<br>Tel.: 022 - 69038800/27/29/31/32/33<br>Email: bimalokpal.mumbai@cioins.co.in | Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane). |
| 15 | **NOIDA**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Bhagwan Sahai Palace<br>4th Floor, Main Road, Naya Bans, Sector 15,<br>Distt: Gautam Buddh Nagar, U.P-201301.<br>Tel.: 0120-2514252 / 2514253<br>Email: bimalokpal.noida@cioins.co.in | State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur. |

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| 16 | **PATNA**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>2nd Floor, Lalit Bhawan,<br>Bailey Road,<br>Patna 800 001.<br>Tel.: 0612-2547068<br>Email: bimalokpal.patna@cioins.co.in | Bihar, Jharkhand. |
| 17 | **PUNE**<br>Insurance Ombudsman<br>Office of the Insurance Ombudsman,<br>Jeevan Darshan Bldg., 3rd Floor,<br>C.T.S. No.s. 195 to 198, N.C. Kelkar Road,<br>Narayan Peth, Pune – 411 030.<br>Tel.: 020-24471175<br>Email: bimalokpal.pune@cioins.co.in | Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region). |

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| S.No | List of Non Medical Expenses |
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| 1 | BABY FOOD |
| 2 | BABY UTILITIES CHARGES |
| 3 | BEAUTY SERVICES |
| 4 | BELTS/ BRACES |
| 5 | BUDS |
| 6 | COLD PACK/HOT PACK |
| 7 | CARRY BAGS |
| 8 | EMAIL / INTERNET CHARGES |
| 9 | FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL) |
| 10 | LEGGINGS |
| 11 | LAUNDRY CHARGES |
| 12 | MINERAL WATER |
| 13 | SANITARY PAD |
| 14 | TELEPHONE CHARGES |
| 15 | GUEST SERVICES |
| 16 | CREPE BANDAGE |
| 17 | DIAPER OF ANY TYPE |
| 18 | EYELET COLLAR |
| 19 | SLINGS |
| 20 | BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES |
| 21 | SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED |
| 22 | Television Charges |
| 23 | SURCHARGES |

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| 24 | ATTENDANT CHARGES |
| 25 | EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) |
| 26 | BIRTH CERTIFICATE |
| 27 | CERTIFICATE CHARGES |
| 28 | COURIER CHARGES |
| 29 | CONVEYANCE CHARGES |
| 30 | MEDICAL CERTIFICATE |
| 31 | MEDICAL RECORDS |
| 32 | PHOTOCOPIES CHARGES |
| 33 | MORTUARY CHARGES |
| 34 | WALKING AIDS CHARGES |
| 35 | OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSp\|TAL) |
| 36 | SPACER |
| 37 | SPIROMETRE |
| 38 | NEBULIZER KIT |
| 39 | STEAM INHALER |
| 40 | ARMSLING |
| 41 | THERMOMETER |
| 42 | CERVICAL COLLAR |
| 43 | SPLINT |
| 44 | DIABETIC FOOT WEAR |
| 45 | KNEE BRACES (LONG/ SHORT/ HTNGED) |
| 46 | KNEE IMMOBILIZER/SHOULDER IMMOBILIZER |
| 47 | LUMBO SACRAL BELT |
| 48 | NIMBUS BED OR WATER OR AIR BED CHARGES |
| 49 | AMBULANCE COLLAR |
| 50 | AMBULANCE EQUIPMENT |
| 51 | ABDOMINAL BINDER |
| 52 | PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES |
| 53 | SUGAR FREE Tablets |
| 54 | CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable) |
| 55 | ECG ELECTRODES |
| 56 | GLOVES |
| 57 | NEBULISATION KIT |
| 58 | ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC] |
| 59 | KIDNEY TRAY |
| 60 | MASK |
| 61 | OUNCE GLASS |
| 62 | OXYGEN MASK |

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| 63 | PELVIC TRACTION BELT |
| 64 | PAN CAN |
| 65 | TROLLY COVER |
| 66 | UROMETER, URINE JUG |
| 67 | AMBULANCE |
| 68 | VASOFIX SAFETY |

## SCHEDULE OF BENEFITS

| Benefits | Sum Insured |
|---|---|
| Sum Insured per Insured Person per Policy Year | Rs 500, 000 |
| Deductible (Rs. In Lacs) (As mentioned in Policy Schedule) | Rs 100,000; 200,000; 300,000; 400,000; 500,000 |
| 1 a) In-patient Treatment | Covered; Hospitalization for minimum 24 hours required. |
| 1 b) Pre-hospitalization | Covered, maximum upto 60 days |
| 1 c) Post-hospitalization | Covered, maximum upto 90 days |
| 1 d) Day Care Procedures | Covered |
| 1 e) Organ Donor | Covered |
| 1 f) Emergency Ambulance | Upto Rs. 2000 per Hospitalisation. |
| 1 g) Domiciliary Treatment | Covered |