HDFC ERGO General Insurance Company Limited

Policy Wordings

my: Optima Secure

Preamble

This Policy is a contract of insurance issued by **HDFC ERGO General Insurance Company Limited** (hereinafter called the 'Company') to the proposer mentioned in the Policy Schedule (hereinafter called the 'Policyholder') to cover the person(s) named in the Policy Schedule (hereinafter called the 'Insured Person(s)'). The Policy is based on the statements and declaration provided by the Policyholder in the Proposal Form as well as in any welcome or other tele-verification calls with the Company's authorized person and is subject to receipt of the requisite premium.

Operating Clause

If during the Policy Period the Insured Person is required to be Hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre or given treatment at Home, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medical Expenses necessarily incurred towards the Covers in force under the Policy, as specified in the Policy Schedule

Provided further that, any amount payable under the Policy shall be subject to the terms of coverage (including Aggregate Deductible, Sub-limits), exclusions, conditions and definitions contained herein. The maximum, total and cumulative liability of the Company under any and all such claims during each Policy Year shall be the Sum Insured (Individual or Floater), including optional covers and other add on covers in force under the Policy, and Cumulative Bonus (if any) specified in the Policy Schedule.

Section A. Definitions

1.1. Standard Definitions

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

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 includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was 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 withinpatient 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 is 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** 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. 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 claims amount. A co-payment does not reduce the Sum Insured.

Def. 9. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 10. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical set -up with 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 criterion asunder: -

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

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

Def. 11. **Day Care Treatment** means those medical treatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

ii) 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 definition.

Def. 12. **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. The deductible is separate from any Aggregate Deductible that may be in-force and applicable under the Policy, as specified in the Policy Schedule

Def. 13. **Dental Treatment** mmeans a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 14. **Disclosure of information norm** means the policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 15. **Domiciliary Hospitalization** means 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.

Def. 16. **Emergency Care** means management for an 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. 17. **Grace Period** means the 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. 18. **Hospital** means any institution established for in patient care and day care treatment ofIllness 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::

i) has qualified nursing staff under its employment round the clock;

ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

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 make these accessible to the insurance company's authorized personnel;

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

Def. 20. **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 means 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. 21. **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. 22. **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. 23. **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. 24. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges

Def. 25. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Def. 26. **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. 27. **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 as the Insured Person and is a Family Member of the Insured Person are not considered as Medical Practitioner under the scope of this Policy.

Medical Practitioner (Definition applicable for the treatment taken outside India) means a licensed medical practitioner acting within the scope of his license and who holds a degree of a recognized institution and is registered by the Authorized Medical Council of the respective country.

Def. 28. **Medically Necessary Treatment** means any treatment, test, medication, or stay in hospital or part of stay in hospital which:

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

iii) must have been prescribed by a medical practitioner;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 29. **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. 30. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

Def. 31. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.

Def. 32. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 33. **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 patient or in-patient**.**

Def. 34. **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.

Def. 35. **Pre-Existing Disease** means any condition, ailment, injury or disease:

a) 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

b) 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. 36. **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. 37. **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. 38. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Def. 39. **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. 40. **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. 41. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Def. 42. **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 and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Def. 43. **Unproven/Experimental Treatment** means the treatment including drug experimental therapy which is based on established medical practice in India, is a treatment experimental or unproven.

1.2. Specific Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular iinclude references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

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 means** completed years on last birthday as on Commencement Date.

Def. 3. **Aggregate Deductible** means a cost-sharing requirement that provides that the Company will not be liable for a specified amount of the covered expenses in respect of all admissible claims made under the Policy in aggregate, and which will apply before any benefits are payable by the Company. The Aggregate Deductible does not reduce the Sum Insured.

Def. 4. **Ambulance** means a motor vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

Def. 5. **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 6. **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year, which shall be applied depending on the year in which a claim is due.

Def. 7. **Base Sum Insured** means the pre-defined limit specified in the Policy Schedule which represents Our maximum, total, and cumulative liability under the Policy for the respective Policy Year, subject to the additional cover amounts which may be available under any optional covers in-force and specified in the Policy Schedule.

Def. 8. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Def. 9. **Biological Attack** or **Weapons** means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 10. **Chemical attack** or **weapons** mmeans the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 11. **Commencement Date means** the date of commencement of insurance coverage under the Policy as specified in the Policy Schedule**.**

Def. 12. **Family Members** means any one or more of the following family members of the Insured Person:

i. Legally wedded spouse.

ii. Parents and parents-in-law.

iii. Dependent Children (i.e. natural or legally adopted) between the Age 90 days to Age 25 years. If the child above 18 years of Age is financially independent, he or she shall be ineligible for coverage under this Policy in the subsequent renewals.

Def. 13. **Home** means the Insured Person's place of permanent residence as specified in the Policy Schedule.

Def. 14. **Insured Person** means persons named in the Policy Schedule who are insured under the Policyand in respect of whom the applicable premium has been received in full.

Def. 15. **Life threatening situation** shall mean a serious medical condition or symptom resulting from Injury or Illness which is not Pre-Existing Disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

Def. 16. **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. 17. **Non-instalment Premium Payment** refers to payment of premium for the entire policy period made in advance as a single premium.

Def. 18. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions and the terms & conditions applicable under the Policy.

Def. 19. **Policy Period** means the period between the Commencement Date and either the Expiry Date specified in the Policy Scheduleor the date of cancellation of this Policy, whichever is earlier.

Def. 20. **Policyholder** means person who has proposed the Policy and in whose name the Policy is issued.

Def. 21. **Policy Schedule** means the Policy Schedule attached to and forming part of this Policyspecifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to,including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 22. **Policy Year** means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Expiry Date, as specified in the Policy Schedule.

Def. 23. **Preventive Health Check-up** means a package of medical test(s) undertaken for general assessment of health status, excluding any diagnostic or investigative medical tests for evaluation of Illness or a disease.

Def. 24. **E-Opinion for Critical Illness means** aa procedure where by upon request of the Insured Person, an independent Medical Practitioner reviews and opines on the treating Medical Practitioner's recommendation as to care and treatment of the Insured Person by reviewing Insured Person's medical status and history.Such an opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

Def. 25. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the predefined limit. The Sub-limit as applicable under the Policy is specified in the Policy Schedule against the relevant Cover in force under the Policy.

Def. 26. **Sum Insured** mmeans the aggregate limit of indemnity consisting of the Base Sum Insured, Cumulative Bonus, Plus Benefit, Secure Benefit and Automatic Restore Benefit (provided that these optional covers are in force for the Insured Person), which represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

Def. 27. **Waiting Period** means a period from the inception of this Policy during which specified diseases/

treatments are not covered. On completion of the Waiting Period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

Section B. Benefits

1. Base Coverage

The Covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy and up to the Sub-limits mentioned in the Policy Schedule. Cumulative Bonus shall be available only if the Cover is specified to be applicable in the Policy Schedule.

Claims made in respect of any of these Covers will affect the eligibility for the additional Covers set out in Section B-2 and Section B-3 below.

1.1. Hospitalization Expenses

The Company shall indemnify Medical Expenses necessarily incurred by the Insured Person for Hospitalization of the Insured Person during the Policy Year due to Illness or Injury, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule for:

a. Room Rent, boarding, nursing expenses as provided by the Hospital / Nursing Home.

b. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.

c. Surgeon, anaesthetist, Medical Practitioner, consultants, specialist Fees during Hospitalization forming part of Hospital bill.

d. Investigative treatments and diagnostic procedures directly related to Hospitalization.

e. Medicines and drugs prescribed in writing by Medical Practitioner.

f. Intravenous fluids, blood transfusion, surgical appliances, allowable consumables and/or enteral feedings. Operation theatre charges.

g. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery.

1.1.1. Other Expenses

i. Expenses incurred on road Ambulance if the Insured Person is required to be transferred to the nearest Hospital for Emergency Care or from one Hospital to another Hospital or from Hospital to Home (within same city) following Hospitalization.

ii. In patient Care Dental Treatment, necessitated due to disease or Injury

iii. Plastic Surgery, necessitated due to Injury

iv. All Day Care Treatments.

Note

i. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.

ii. The Hospitalization must be for Medically Necessary Treatment, and prescribed in writing by Medical Practitioner.

1.2. Home Health Care

The Company shall indemnify the Medical Expenses incurred by the Insured Person on availing treatment at Home during the Policy Year, if prescribed in writing by the treating Medical Practitioner, provided that:

a. The treatment in normal course would require In-patient Care at a Hospital, and be admissible under Section B-1.1 (Hospitalization Expenses).

b. The treatment is pre-authorized by the Company as per procedure given under Claims Procedure - Section E-1.

c. Records of the treatment administered, duly signed by the treating Medical Practitioner,are maintained for each day of the Home treatment.

This Cover is not available on reimbursement basis.

1.3. Domiciliary Hospitalization

The Company shall indemnify the Medical Expenses incurred during the Policy Year on Domiciliary Hospitalization of the Insured Person prescribed in writing by treating Medical Practitioner, provided that:

a. the condition of the Insured Person is such that he/she could not be removed/admitted to a Hospital.

or,

b. the Medically Necessary Treatment is taken at Home on account of non-availability of room in a Hospital.

1.4. AYUSH Treatment

The Company shall indemnify the Medical Expenses incurred by the Insured Person only for Inpatient Care under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the Sub-limit specified against this Cover in the Policy Schedule, in any AYUSH Hospital.

1.5. Pre-Hospitalization Expenses

The Company shall indemnify the Pre-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section B-1.1 (Hospitalization Expenses), for up to 60 days immediately prior to the date of admissible Hospitalization covered under the Policy.

1.6. Post-Hospitalization Expenses

The Company shall indemnify the Post-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section B-1.1 (Hospitalization Expenses), for up to 180 days from the date of discharge from the Hospital, following an

admissible Hospitalization claim under the Policy.

1.7. Organ Donor Expenses

The Company shall indemnify the Medical Expenses covered under Section B-1.1(Hospitalization Expenses) which are incurred by the Insured Person during the Policy Year towards the organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient, subject to the following conditions:

a. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and/or regulations.

b. Recipient Insured Person's claim under Section B-1.1 (Hospitalization Expenses) is admissible under the Policy.

c. Expenses listed below are excluded from this Cover:

   i. The organ donor's Pre-Hospitalization Expenses and Post-Hospitalization Expenses.

   ii. Expenses related to organ transportation or preservation.

   iii. Any other Medical Expenses or Hospitalization consequent to the organ harvesting.

1.8. Cumulative Bonus (CB) [Applicable only to Optima Suraksha plan]

On Renewal of this Policy with the Company without a break, a sum equal to 10% of the Base Sum Insured of the expiring Policy shall be provided as CB irrespective of any claims and shall be available under the Renewed Policy subject to the following conditions:

Notes:

a. In case where the Policy is on individual basis as specified in the Policy Schedule, the CB shall be added and available individually to the Insured Person.

b. In case where the Policy is on floater basis, the CB shall be added and available to the family on floater basis.

c. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

d. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.

e. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

f. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

g. If the Sum Insured under the Policy has been increased at the time of Renewal, the CB shall be calculated on the Sum Insured of the last completed Policy Year.

h. If the Policy Period is of two/three years, any CB that has accrued for the first/second Policy Year shall be credited post completion of each Policy Year.

i. New Insured Person added to the Policy during subsequent Renewals will be eligible for CB as per their Renewal terms.

j. CB shall be available only if the Cover is specified to be applicable in the Policy Schedule.

2. Optional Covers

The Covers listed below are optional covers. An optional cover is applicable to an Insured Person only if it is specified in the Policy Schedule to be in force for that Insured Person, and such optional cover will be available in accordance with the procedures set out in this Policy and up to the Sub-limits mentioned in the Policy Schedule.

The optional covers shall apply to all Insured Person(s) once selected, without any individual selection.

Note: Please refer to 'Annexure C' for Optional Covers which are in-built in Your plan.

2.1 Emergency Air Ambulance

The Company shall indemnify expenses incurred by the Insured Person during the Policy Year towards Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid Ambulance transportation that ground transportation cannot provide from the site of first occurrence of the Illness or Accident to the nearest Hospital. The claim is subject to a maximum of Sum Insured as specified in the Policy Schedule against this Cover, and subject to the following conditions:

a. The air Ambulance transportation is advised in writing by a Medical Practitioner.

b. Medically Necessary Treatment is not available at the location where the Insured Person is situated at the time of emergency.

c. The air Ambulance provider is a registered entity in India (except Section B-2.9 (Global Health Cover (Emergency Treatments Only)) and Section B-2.10 (Global Health Cover (Emergency and Planned Treatments Only))

d. The Insured Person is in India and the treatment

is taken in India only(except Section B-2.9 (Global Health Cover (Emergency Treatments Only)) and Section B-2.10 (Global Health Cover (Emergency and Planned Treatments Only)).

e. No return transportation to the Insured Person's Home or elsewhere by the air Ambulance will be covered under this Cover.

f. A claim for the same Hospitalization is admissible under Section B-1.1 (Hospitalization Expenses) OR Section B-2.9 (Global Health Cover (Emergency Treatments Only)) OR Section B-2.10 (Global Health Cover (Emergency and Planned Treatments Only)).

g. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

2.2 Daily Cash for Shared Room

The Company shall pay a daily cash amount as specified in Policy Schedule for each continuous and completed 24 hours of Hospitalization during the Policy Year if the Insured Person is Hospitalised in shared accommodation in a Network Provider Hospital and such Hospitalization exceeds 48 consecutive hours.

Specific Exclusions:

a. The Coveris not available for the time spent by the Insured Person in an Intensive Care Unit (ICU).

b. The claim for the same Hospitalization is not admissible under Section B-1.1 (Hospitalization Expenses).

c. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

2.3 Protect Benefit

The Company shall indemnify the Insured Person for the Non-Medical Expenses listed under Annexure B to this Policy incurred in relation to a claim admissible under Section B-1 (Base Coverage) during the Policy Year.

Exclusion (k) of SectionC.2 – Specific Exclusions shall not apply to this Cover.

2.4 Plus Benefit

On Renewal of this Policy with the Company without a break, a sum equal to 50% of the Base Sum Insured under the expiring Policy will be added to the Sum Insured available under the Renewed Policy subject to the following conditions:

a. The applicable Plus Benefit under this Cover can only be accumulated up to 100% of Base Sum Insured, and will be applicable only to the Insured Person covered under the expiring Policy and who continues to remain insured on Renewal.

b. The applicable Plus Benefit shall be applied annually only on completion of each Policy Year, and once added, the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy.

c. This Cover will be applied irrespective of number of claims made under the expiring Policy.

d. This applicable Plus Benefit under this Cover can be utilized only for claims admissible under Section B-1 (Base Coverage) and Section B-2.3 (Protect Benefit) of the Policy.

Notes:

i. In case where the Policy is issued on an individual basis, the Plus Benefit shall be added and available individually to the Insured Person. In case where the Policy is on floater basis, the Plus Benefit shall be added and available to all Family Members on a floater basis.

ii. Plus Benefit shall be available only if the Policy is renewed and due premium is received within the Grace Period.

iii. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Plus Benefit for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the Plus Benefit to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.

iv. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the Plus Benefit of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

v. If the Sum Insured has been reduced at the time of Renewal, the applicable Plus Benefit shall be reduced in the same proportion to the Sum Insured in current Policy.

vi. If the Sum Insured under the Policy has been increased at the time of Renewal, the Plus Benefit shall be calculated on the Sum Insured of the last completed Policy Year.

vii. If the Policy Period is of two or three years, the Plus Benefit shall be credited post completion of each Policy Year, and will be available for any claims made in the subsequent Policy Year.

viii. New Insured Person added to the Policy during subsequent Renewals will be eligible for the Plus Benefit as per their Renewal terms.

2.5 Secure Benefit

An additional amount as specified in the Policy

Schedule will be available to the Insured Person as Sum Insured for all claims admissible under Section B (Base Coverage) and Section B-2.3 (Protect Benefit) during the Policy Year, subject to the following conditions:

a. This Secure Benefit shall be applied only once during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.

b. The Secure Benefit can be utilized for any number of claims admissible under the Policy during the Policy Year.

c. The Secure Benefit will be applicable only after exhaustion of Base Sum Insured.

d. In case of family floater policy, the Secure Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

2.6 Automatic Restore Benefit

In the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year irrespective of the utilization of the Cumulative Bonus, Plus Benefit, and Secure Benefit, the Company shall restore the Sum Insured up to the Base Sum Insured (as applicable under the current Policy Year) for any subsequent claims admissible under Section B (Base Coverage) and SectionB-2.3 (Protect Benefit) (if in force), subject to the following conditions:

a. This Automatic Restore Benefit shall be applied only once during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.

b. The Base Sum Insured restoration under the Automatic Restore Benefit would be triggered only upon complete or partial utilization of the Base Sum Insured by the way of first claim admitted under the Policy, and be available for subsequent claims thereafter in the Policy Year, for all Insured Persons.

c. In case of a family floater policy, the Automatic Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.s.

2.7 Aggregate Deductible

The Insured Person shall bear an amount equal to the Aggregate Deductible specified on Policy Schedule for all admissible claims made by the Insured Person and assessed by the Company in a Policy Year. The liability of the Company to pay the admissible claim under that Policy Year will commence only once the specified Aggregate Deductible has been exhausted. This Cover shall be subject to the following conditions:

a. This Cover is applicable on annual aggregate basis and can be opted only at inception of the Policy or at subsequent Renewals. Aggregate Deductible can be increased at the time of Renewal.

b. In case of Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.

c. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year.

d. The Aggregate Deductible is not applicable to Sections B-2.8 (E-Opinion for Critical Illness), Section B-3 (Preventive Health Check Up), Sections B-2.9 (Global Health Cover (Emergency Treatments Only)), Section B-2.10 (Global Health Cover (Emergency and Planned Treatments Only)) and Section B-2.11 (Overseas Travel Secure). Hence, coverage under Section B-2.8 (E-opinion for Critical Illness), Section B-3 (Preventive Health Check Up), Section B-2.9 (Global Health Cover (Emergency Treatments Only)), Section B-2.10 (Global Health Cover (Emergency and Planned Treatments Only)) and Section B-2.11 (Overseas Travel Secure) can be availed irrespective of whether the chosen Aggregate Deductible limit is breached or not, during the Policy Year.

e. Preventive Health Check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.

f. Preventive Health Check-up benefit, Secure Benefit, Cumulative Bonus / Plus Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force.

2.7.1 Waiver of Aggregate Deductible

The Insured Person will have the option to either reduce or waive the applicable deductible only once in the lifetime of the Policy and at Renewal, subject to underwriting and only if all the below mentioned conditions are fulfilled:

a. Age of eldest Insured Person should be less than 50 years at the time of purchasing this Policy (with aggregate deductible)

b. Only after completion of 5 continuous Policy Years with Us in this Policy (with aggregate deductible) and the age of eldest Insured Person covered in the Policy should be less than 61 years at the time of availing this option.

c. Continuity benefits of waiting period accrued as per expiring Policy Year (with aggregate

deductible) shall be offered even after availing this option.

d. This option shall apply to all Insured Person(s) once selected, without any individual selection.

e. Post availing 'Waiver of Aggregate Deductible' option, premium will be charged as per the modification made.

2.8 E-Opinion for Critical Illness

The Company shall indemnify the expenses incurred by the Insured Person towards E-Opinion for Critical Illness availed from a Medical Practitioner in respect of any Major Medical Illness (of the nature listed below) through the Network Provider specified in the Policy Schedule, subject to the following conditions:

a. Benefit under this cover shall be subject to the eligible geography of the Network Provider. The Insured Person may contact the Company or refer to its website for details on eligible Network Provider(s).

b. The Benefit under this Cover can be availed by an Insured Person only once in a Policy Year, and shall be available for each Insured Person in case the Policy is issued on a floater basis.

c. The Insured Person is free to choose whether or not to obtain the E-Opinion for Critical Illness, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his/her health. It is understood and agreed that any information and documentation provided to the Company for the purpose of seeking the E-Opinion for Critical Illness shall be shared with the Network Providers.

d. Availing this benefit shall not have any impact on the Sum Insured.

Disclaimer – E - *The Insured Person is free to choose whether or not to obtain the E-Opinion for Critical Illness, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his/her health. It is understood and agreed that any information and documentation provided to the Company for the purpose of seeking the E-Opinion for Critical Illness shall be shared with the Network Providers*

Major Medical Illness

1	Cancer of specified severity
2	Open Chest CABG
3	Kidney failure requiring regular dialysis
4	Myocardial Infarction (First Heart Attack of specified severity)
5	Open Heart Replacement or Repair of Heart Valves
6	Major Organ/Bone Marrow Transplantation
7	Multiple Sclerosis with persisting symptoms
8	Permanent Paralysis of Limbs
9	Stroke resulting in permanent symptoms
10	Benign Brain Tumour
11	Coma of specified severity
12	Parkinson's Disease
13	Alzheimer's Disease
14	Surgery of Aorta
15	End Stage Liver Failure
16	Deafness
17	Loss of Speech
18	Third Degree Burns
19	Medullary Cystic Disease
20	Motor Neurone Disease with permanent symptoms
21	Muscular Dystrophy
22	Infective Endocarditis
23	Primary (Idiopathic) Pulmonary Hypertension
24	Dissecting Aortic Aneurysm
25	Systemic Lupus Erythematous with Lupus Nephritis
26	Apallic Syndrome
27	Aplastic Anaemia
28	Bacterial Meningitis
29	Cardiomyopathy
30	Other serious coronary artery disease
31	Creutzfeldt-Jakob Disease (CJD)
32	Encephalitis
33	End Stage Lung Failure
34	Fulminant Hepatitis
35	Eisenmenger's Syndrome
36	Major Head Trauma
37	Chronic Adrenal Insufficiency (Addison's Disease)
38	Progressive Scleroderma
39	Progressive Supranuclear Palsy
40	Blindness
41	Chronic Relapsing Pancreatitis
42	Elephantiasis

43	Brain Surgery
44	HIV due to blood transfusion and occupationally acquired HIV
45	Terminal Illness
46	Myelofibrosis
47	Pheochromocytoma
48	Crohn's Disease
49	Severe Rheumatoid Arthritis
50	Severe Ulcerative Colitis
51	Angioplasty

2.9 Global Health Cover (Emergency Treatments Only)

On availing this cover, the below mentioned benefits shall be extended for Emergency Medical Expenses which are diagnosed and incurred outside India:

B-1.1	Hospitalization Expenses
B-1.4	AYUSH Treatment
B-1.7	Organ Donor Expenses
B-2.1	Emergency Air Ambulance
B-2.3	Protect Benefit
B-2.4	Plus Benefit
B-2.8	E Opinion for Critical Illness

A. Global Health Cover (Emergency Treatments Only) is applicable subject to following terms and conditions

i. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Base Sum Insured and Plus Benefit (if available).

ii. Section B-2.7 (Aggregate Deductible) will not be applicable for any claim under this cover. However, a Per Claim Deductible of Rs. 10,000 will apply separately for each and every claim (except Section B-2.8 'E Opinion for Critical Illness') under this cover.

iii. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case to case basis.

iv. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.

v. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

vi. We would not be liable to pay any claim wherein the medical treatment taken outside India has not commenced within the first 45 days of a trip.

Note: Each trip shall be deemed to start within the Policy Period and from the date Insured Person finally boards the flight (scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket) to leave from India.

vii. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.

B. Specific Exclusions applicable to Global Health Cover (Emergency Treatments Only)

i. Any Planned treatments

ii. In case we have paid a Hospitalization claim under this benefit, Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses related to the claim whether incurred overseas or within India are not payable under this Policy.

iii. Treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed till the Insured Person returns to India.

iv. Medical treatment taken outside India if that is the sole reason or one of the reasons for the journey.

v. Any treatment of orthopaedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.

vi. Oncological (Cancer) diseases

vii. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.

2.10 Global Health Cover (Emergency & Planned Treatments)

On availing this cover, the below mentioned benefits shall be extended for both planned and Emergency Medical Expenses outside India:

B-1.1	Hospitalization Expenses
B-1.4	AYUSH Treatment
B-1.5	Pre-Hospitalization cover
B-1.6	Post-Hospitalization cover
B-1.7	Organ Donor Expenses
B-2.1	Emergency Air Ambulance
B-2.3	Protect Benefit
B-2.4	Plus Benefit
B-2.8	E Opinion for Critical Illness

Global Health Cover (Emergency & Planned Treatments) is applicable subject to following terms and conditions

i. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Base Sum Insured and Plus Benefit (if available).

ii. Section B-2.7 (Aggregate Deductible) will not be applicable for any claim under this cover. However, a Per Claim Deductible of Rs. 10,000 will apply separately

for each and every claim (except Section B-2.8 'E Opinion for Critical Illness') under this cover.

iii. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case to case basis.

iv. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.

v. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

vi. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.

vii. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.

viii. Pre-hospitalization Medical Expenses and/or Posthospitalization Medical Expenses incurred and paid overseas shall be indemnified only if the concerned hospitalization was undertaken overseas and claim for such hospitalization was admissible under 'Global Health Cover (Emergency & Planned Treatments)'.

ix. In case we have accepted an overseas hospitalization claim under 'Global Health Cover (Emergency & Planned Treatments)' then

  i) Pre-hospitalization Medical Expenses and/or Posthospitalization Medical Expenses concerning such hospitalization shall be paid only if the same have been incurred and paid overseas (as per details in invoice supporting documents).

  ii) Any Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expense emanating from an overseas hospitalization claim but incurred in India shall not be payable under the policy.

x. In case of Migration and Portability, all waiting periods shall apply afresh only for planned hospitalization claims admissible under 'Global Health Cover (Emergency & Planned Treatments)'. Such waiting periods shall commence from the date 'Global Health Cover (Emergency & Planned Treatments) has come into force.

2.11 Overseas Travel Secure

i) This optional cover can only be opted along with Optima Secure Global Plan or Optima Secure Global Plus Plan on payment of additional premium.

ii) Claim under this benefit shall be payable upto Sum Insured and is admissible only if both the below conditions are fulfilled:

  a. The overseas treating Medical Practitioner has advised a minimum hospitalization of 5 consecutive days and has also advised the requirement of an accompanying person during treatment.

  b. We have accepted a claim under

    - Section 2.9 Global Health Cover (Emergency Treatments Only) OR
    - Section 2.10 Global Health Cover (Emergency & Planned Treatments)

iii) There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.

iv) We will indemnify the following expenses incurred overseas:

A. Travel Expenses

a. We will indemnify actual expenses incurred on air tickets (most basic economy class airfare in a common carrier) for the Hospitalized Insured Person and any one accompanying person to attend to the Insured Person's medical treatment overseas.

  i. For Emergency hospitalization cases, we shall indemnify for the following travel expenses

    - For the accompanying person, two way expense incurred on air tickets from his City of Residence OR India to the airport nearest to the site of hospitalization shall be provided.
    - For the Hospitalized Insured Person, we shall only indemnify air expenses incurred to transport him from the airport nearest to the site of Hospitalization to India.

  ii. For planned hospitalization cases, we shall indemnify for the following travel expenses

    - For the accompanying person, two way expense incurred on air tickets from his City of Residence OR India to the airport nearest to the site of h ospitalization shall be provided.
    - For the Hospitalized Insured Person, we shall indemnify two way expense incurred on air tickets from India to the airport nearest to the site of hospitalization shall be provided.

  iii. In case the accompanying person was already present in that city at the time of such hospitalization, we shall only indemnify air expenses incurred to transport him from the airport nearest to the site of Hospitalization to his City of Residence OR India.

b. Any kind of other transportation expenses except the expense on airfare is not payable under this optional cover

Note – For Insured Person, City of Residence shall be considered as declared in the Proposal Form and mentioned in the Policy Schedule. Whereas, for

accompanying person, City of Residence shall be considered as mentioned in the legal document issued by the Government of that particular country.

B. Accommodation Expenses

a. We will also indemnify the cost of accomodation, at a place near to the site of Hospitalization, for the accompanying person, to attend to the Insured Person's medical treatment overseas.

b. Cost of accomodation overseas shall be indemnified upto Rs. 15,000 per day, only for the days wherein the Insured person was hospitalized overseas; maximum upto 30 days in a Policy Year.

c. Any other kind of supplementary expenses such as meals, laundry, transport are not payable under this cover.

3. Preventive Health Check-up

On each continuous Renewal of the Policy, the Company will indemnify the cost of a Preventive Health Check-up for the Insured Person who was insured during the previous Policy Year, up to the amounts specified in this Cover below.

i. This Cover does NOT carry forward if it is not claimed and shall not be provided if the Policy is not Renewed further.

ii. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

iii. For Individual Policies, the below mentioned limits are applicable for each Insured Person per Policy Year.

iv. This benefit is available every year post completion of the first Policy Year

Base Sum Insured under the Policy	**5 Lacs**	**10 Lacs**	**15 Lacs**	**20, 25, 50 & 75 Lacs**	**100 & 200 Lacs**
Limit of Cover	Rs. 1,500	Rs. 2,000	Rs. 4,000	Rs. 5,000	Rs. 8,000

For Family Floater Policies, the below mentioned limits are applicable cumulatively for all Insured Persons per Policy Year.

Base Sum Insured under the Policy	**5 Lacs**	**10 Lacs**	**15 Lacs**	**20, 25, 50 & 75 Lacs**	**100 & 200 Lacs**
Limit of Cover	Rs. 2,500	Rs. 5,000	Rs. 8,000	Rs. 10,000	Rs. 15,000

Section C. Exclusions

The Company shall not make 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 the Policy:

1. Standard Exclusions

All the Waiting Periods and exclusions listed below shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

a. **Pre-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 Insured increase.

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

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

b. **Specified Disease/Procedure waiting period- Code – Excl02**

i. 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.

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

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

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

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

vi. List of specific diseases/procedures is provided below:

Illnesses

Pancreatitis	Non infective Arthritis	Pilonidal sinus
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g. Kidneystone, Urinary Bladder Stone	Benign tumors, cysts, nodules, polyps including breast lumps
All forms of Cirrhosis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
Cataract and other disorders of lens and Retina	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors
Osteoarthritis and osteoporosis	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Fibroids (fibromyoma)	Benign Hyperplasia of Prostate	

Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy	Hernia
Dilatation and curettage (D&C)	Nasal concha resection	Surgery for prolapsed inter vertebral disc
Myomectomy for fibroids	Surgery of Genito urinary system unless necessitated by Malignancy	Surgery for varicose veins and varicose ulcers
Surgery on prostate	Cholecystectomy	Surgery for Perianal Abscesses
Hydrocele/Rectocele	Joint replacement surgeries	Surgery for Nasal septum deviation
Ligament, Tendon and Meniscal tear	Hysterectomy	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries
Endometriosis	Prolapsed Uterus	Rectal Prolapse
Varicocele	Retinal detachment	Glaucoma
Nasal polypectomy		

c. **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.

d. **Investigation & Evaluation: Code Excl04**

i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

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

e. **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:

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.

f. **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:

1) Obesity-related cardiomyopathy

2) Coronary heart disease

3) Severe sleep apnoea

4) Uncontrolled type 2 diabetes

g. **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.

h. **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.

i. **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.

j. **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.

k. **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.

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

m. 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.**

n. 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.**

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

p. **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.

q. **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.

r. **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.

2. Specific Exclusions:

In addition to the foregoing general exclusions, the Company shall not be liable to make any payment under this Policy caused by or arising out of or attributable to any of the following:

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

b. Aggregate Deductible - Claims/claim amount falling within Aggregate Deductible limit if opted and in force, as specified in the Policy Schedule.

c. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

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

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

f. Congenital external diseases, defects or anomalies.

g. Stem cell harvesting.

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

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

j. Vaccination including inoculation and immunisations (except post animal bite treatment).

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

l. Treatment taken on outpatient basis.

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

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

o. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively), prosthesis, corrective devices

external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident.

p. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. Drugs or treatments which are not supported by a prescription.

q. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

Section D. General Terms and Clauses

1. Standard General Terms & Clauses

1.1. 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.

1.2. 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.

1.3. Claim Settlement (provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

1.4. 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.

1.5. Multiple Policies

a. 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.

b. 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.

c. 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.

d. Where the 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.

1.6. Moratorium Period

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 limits.

1.7. 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 mis-statement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the Insurer.

1.8. 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 thirty 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:

a. 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

b. 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

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

1.9. 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..

1.10. 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

1.11. 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

1.12. Cancellation

a. 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

b. 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.

c. 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

d. 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.

1.13. Premium Payment in Instalments

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

a. Grace Period as mentioned in the table below would be given to pay the instalment 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

b. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

c. 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

d. No interest will be charged If the instalment premium is not paid on due date

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

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

g. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

1.14. 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.

1.15. 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.

1.16. 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.

1.17. Redressal of Grievance

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

- Website: www.hdfcergo.com
- Contact Us: 022 6234 6234 / 0120 6234 6234
- E-mail: grievance@hdfcergo.com
- Contact Details for Senior Citizen: 022 – 6242 – 6226
- E-mail specific for Senior citizens : seniorcitizen@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
Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contact 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-400078	The Chief Grievance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. ParekhMarg, Churchgate, Mumbai – 400020

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

Latest contact details of Offices of Insurance Ombudsman are provided at Annexure A.

2. Specific General Terms and Clauses

2.1. Non-Disclosure or Misrepresentation of Pre-Existing Disease

The Company may, notwithstanding and without prejudice to its rights under the standard general terms and clauses above, also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of non-disclosure or misrepresentation of Pre-Existing Diseases, subject to prior consent from Policyholder:

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

b. Incorporate additional Waiting Period of not exceeding 3 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 Policy Year of issuance of Policy or Renewal, whichever is later.

2.2. Utilization of Sum Insured

The sequence of utilization of Sum Insured in this Policy, subject to the optional covers in force under the Policy, will be as follows;

a. Base Sum Insured.

b. Cumulative Bonus/Plus Benefit (if applicable).

c. Secure Benefit (if applicable).

d. Automatic Restore Benefit (subject to utilization of the Base Sum Insured in whole or in part).

A single claim in a Policy Year cannot exceed the sum of Base Sum Insured, Cumulative Bonus (if applicable), Plus Benefit (if applicable) and Secure Benefit (if applicable).

2.3. Geography

This Policy provides coverage throughout the territory of India, except under Section B-2.8 (E-Opinion for Critical Illness) ,Section B-2.9 Global Health Cover (Emergency Treatments Only) ,Section B-2.10 Global Health Cover (Emergency & Planned Treatments), B-2.11 Overseas Travel Secure and as may be specified in the Schedule of Coverage in the Policy Schedule.

2.4. Loadings

a. The Company may apply loading on the premium, specific Waiting Period or permanent exclusions, based on the declarations made in the Proposal Form and the health status, habits and lifestyle, past medical records, and the results of the pre-Policy medical examination of the persons proposed to be insured under the Policy.

b. The maximum medical underwriting loading shall not exceed 100% for each condition and a total of 150% for each Insured Person.

c. Loadings shall be applied from Commencement Date including subsequent Renewal(s), and on increased Sum Insured.

d. Proposer shall be informed about the proposed loading with premium, specific Waiting Period or permanent exclusion (if any) through a counter offer letter and Policy will be issued only on specific acceptance within 15 days of the receipt of such counter offer letter. In case the Company does not receive any response to the counter offer letter from the proposer within 15 days, the application shall be cancelled and any premium received shall be refunded within 7 days.

2.5. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change or modification that the Company makes will be evidenced by a written endorsement signed and stamped by the Company.

2.6. Communication & Notice

Policy and any communication related to the Policy shall be sent to through electronic modes or to the address of the following:

a. The Policyholder's, at the address/ e-mail address specified in the Policy Schedule.

b. To the Company, at the address specified in the Policy Schedule.

c. Insurance agents, brokers, other person or entity is/are not authorised to receive any notice on the behalf of the Company, unless stated in writing by the Company.

2.7. Premium Tier

The premium payable under the Policy will be computed basis the city of residence provided by the Insured Person in the Proposal Form. Classification of cities would be as under:

a. Tier 1: Delhi, National Capital Region (NCR), Mumbai, Mumbai Suburban, Thane and Navi Mumbai, Surat, Ahmedabad and Vadodara.

b. Tier 2: Rest of India.

No co-payment shall apply if Insured Person from Tier 2 avails a treatment in Tier 1.

2.8. Instalment Premium payment through Auto Debit/ECS Facility

a. If premium payment is opted for by instalments through auto debit/ECS facility, a separate authorization form shall be submitted by Insured Person specifying the frequency chosen for premium to be debited.

b. Where there is a change either in the terms and conditions of the coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh.

c. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable.

d. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode.

2.9. Dispute Resolution Clause

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

Section E. Other Terms & Conditions

1. Claims Procedure

1.1. Notification of a Claim

Notice with full particulars shall be sent to the Company as under:

a. Within 24 hours from the date of emergency Hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

b. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization or decision to avail treatment under Section B-1.2 (Home Health Care).

1.2. Procedure for Cashless Claims In India

a. Treatment may be taken in a Network Provider and is subject to pre authorization by the Company.

b. Cashless request form is available with the Network Provider.

c. The Network Provider shall obtain the relevant information from the Insured Person / Policyholder and send a Cashless Facility request to the Company for authorization.

d. The Company upon getting cashless request form and related medical information from the Insured Person/ Network Provider shall issue pre-authorization letter to the Network Provider after verification.

e. At the time of discharge, the Insured Person shall verify and sign the discharge papers along with final bill, pay for non-medical and inadmissible expenses.

f. The Company reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.

g. In case of denial of cashless access, the Insured Person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company for reimbursement.

1.3. Procedure for Cashless Claims Outside India

a. You shall intimate the Claims to us through any

available mode of communication as specified in the Policy, Health Card or our Website

b. Treatment may be taken in a Network Provider and is subject to pre authorization by the Company. Process for obtaining Pre-Authorization is mentioned below:

i. **We** shall send R1the Insured Person for signature and consent.

ii. After receiving the signed Release of Information form, **We** will retrieve hospitalization documents along with invoices

iii. If these details are not provided in full or are insufficient for **Us** to consider the request, We will request additional information or documentation

iv. On receipt of the complete documents **We** may

- issue the guarantee of payment specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable

  or

- reject the request for pre-authorization specifying reasons for the rejection

1.4. Procedure for Cashless Claims in case of Home Health Care (Section B-1.2)

On receipt of duly filled pre authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company. On receipt of the complete documents the Company may:

a. issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or

b. reject the request for pre-authorization specifying reasons for the rejection.

1.5. Conditions for obtaining Cashless Facility within India

a. Cashless facility can be availed only at Company's Network Provider. The complete list of Network Providers and empanelled service providers is available on Company's website and can also be obtained by contacting the Company.

b. The Company reserves the right to modify, add or restrict any Network Provider for Cashless facility at its sole discretion. The same shall be duly updated on the Company's website. The Insured Person shall check the updated list of Network Providers before applying for cashless claim.

c. Pre-authorization issued by the Company shall be valid for 15 days from the date of issuance (or expiry of the Policy, whichever is earlier).

d. The Company shall make payment for the Cashless facility to the authorized amount, directly to the Network Provider.

1.6. Procedure for Reimbursement Claims

For reimbursement of claims, the Insured Person shall submit the necessary documents to the Company within the prescribed time limit as specified hereunder.

Type of Claim	Prescribed Time limit
Reimbursement of Hospitalization, Day Care Treatment or Pre-Hospitalization Expenses	Within 30 days of date of discharge from Hospital.
Reimbursement of Post-Hospitalization Expenses	Within 15 days from completion of post Hospitalization treatment.

1.7. List of documents required for a Claim

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

a. Duly Completed claim form,

b. Photo ID and Age Proof,

c. Copy of the Hospital's Registration Certificate/ Hospital Registration number in case of Hospitalization in any non-Network Provider of the Company or certificate from Hospital authorities providing facilities available including number of beds

d. Discharge Card / Day Care Summary / Transfer Summary,

e. Final Hospital bill with all original deposit and final payment receipt and refund receipt(s), if advance amount refunded,

f. Invoice with payment receipt and implant stickers for all implants used during Surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery,

g. All previous consultation papers indicating history and treatment details for current Illness and advice for current Hospitalization,

h. All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre,

i. All medicine / pharmacy bills along with prescription by Medical Practitioner,

j. MLC / FIR Copy – in Accident cases only,

k. History of alcohol consumption or any intoxication certified by first treating doctor in case of Accident cases,

l. Copy of Death Summary and copy of Death Certificate (in death claims only),

m. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details, and patient's progress (to be

submitted wherever required by the Company).

n. Invoice for vaccination and payment receipt,

o. Original invoices for the expenses incurred towards ambulance facility along with details of loss in the Company's prescribed format,

p. KYC documents (in all claims above Rs. 1 lakh) of the Policyholder as per AML guidelines,

q. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf),

r. Legal heir/succession certificate, wherever applicable,

s. Additional documents for claims outside India of Insured Person and Accompanying Person (as applicable) –

   i. Passport copy with entry and exit stamps

   ii. Flight Tickets and Boarding Pass, if applicable

   iii. Accommodation Invoices, if applicable

   iv. Written advice from the overseas treating Medical Practitioner for requirement of an accompanying person during treatment.

t. Any other relevant document required by Company for assessment of the claim.

Note:

i. The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.

ii. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

iii. If requested by the Company, at the Company's cost, the Insured Person must submit to medical examination by Medical Practitioner appointed by the Company as often as it is considered reasonable and necessary and Company's representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment, and to investigate the circumstances pertaining to the claim.

iv. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

2. Contact Us

	Within India	**Outside India**
Claim Intimation:	Customer Service No. 022-62346234 / 0120-62346234 Email: healthclaims@hdfcergo.com Reimbursement Claim Intimation: Visit www.hdfcergo.com - > Help - > Claim Registration	Global Contact No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Emailtravelclaims@hdfcergo.com
Claim document submission at address:	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-15th Floor, C - 25, Sector 62, Noida – 0120 398 8360	HDFC ERGO General Insurance Co Ltd 6th Floor, Leela Business Park, Andheri Kurla Road, Andheri East, Mumbai-400059, Ph-022 66383600

Annexure A - Contact details of Offices of Insurance Ombudsman

OFFICE DETAILS	JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU 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, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR 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, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	State of Punjab, Haryana (excluding 4 districts vizGurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu &Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 districts of Haryana vizGurugram, Faridabad, Sonepat and Bahadurgarh)

OFFICE DETAILS	JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
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 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, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 /2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCH Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 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.

OFFICE DETAILS	JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P - 201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor,C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Anexure B- Items for which Coverage is not available in the Policy (Non-Medical Expenses)

S. No.	Item
1	Baby Food
2	Baby Utilities Charges
3	Beauty Services
4	Belts/ Braces
5	Buds
6	Cold Pack/Hot Pack
7	Carry Bags
8	Email / Internet Charges
9	Food Charges (Other Than Patient's Diet Provided By Hospital)
10	Leggings
11	Laundry Charges
12	Mineral Water
13	Sanitary Pad
14	Telephone Charges
15	Guest Services
16	Crepe Bandage
17	Diaper of any Type
18	Eyelet Collar
19	Slings
20	Blood Grouping and Cross Matching Of Donors Samples
21	Service Charges Where Nursing Charge also Charged
22	Television Charges
23	Surcharges
24	Attendant Charges
25	Extra Diet of Patient (Other Than That Which Forms Part of Bed Charge)
26	Birth Certificate
27	Certificate Charges
28	Courier Charges
29	Conveyance Charges
30	Medical Certificate
31	Medical Records
32	Photocopies Charges
33	Mortuary Charges
34	Walking Aids Charges
35	Oxygen Cylinder (For Usage outside Hospital)
36	Spacer
37	Spirometre
38	Nebulizer Kit
39	Steam Inhaler
40	Armsling
41	Thermometer
42	Cervical Collar
43	Splint
44	Diabetic Foot Wear
45	Knee Braces (Long/ Short/ Hinged)
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, Ortho kit, Recovery Kit, etc.]
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety

Annexure C - Plan Chart:

	Plans	Optima Suraksha	Optima Secure	Optima Super Secure	Optima Secure Global	Optima Secure Global Plus
	Base Sum Insured	5/10/15/20/ 25/50 Lakhs	5/10/15/20/25/50/ 100/200 Lakhs	10/15/20/25/50/ 100/200 Lakhs	100/200Lakhs	25/50/75/100/200 Lakhs
	^Geography	India only	India only	India only	Worldwide including India	Worldwide including India
Base Coverages						
1	Hospitalization Expenses	100%	100%	100%	100%	100%
1.1	Room Rent	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals
1.2	Road Ambulance	Covered	Covered	Covered	Covered	Covered
1.3	Dental Treatment	Covered	Covered	Covered	Covered	Covered
1.4	Plastic surgery	Covered	Covered	Covered	Covered	Covered
1.5	Day Care Treatment	Covered	Covered	Covered	Covered	Covered
2	Home Healthcare	Covered	Covered	Covered	Covered (India only)	Covered (India only)
3	Domiciliary Hospitalization	Covered	Covered	Covered	Covered (India only)	Covered (India only)
4	AYUSH Treatment	Covered	Covered	Covered	Covered	Covered
5	Pre-Hospitalization	60 days	60 days	60 days	60 days (India only)	60 days
6	Post-Hospitalization	180 days	180 days	180 days	180 days (India only)	180 days
7	Organ Donor Expenses	Covered	Covered	Covered	Covered	Covered
8	Cumulative Bonus	Covered	Not Covered	Not Covered	Not Covered	Not Covered
Optional Covers						
1	Emergency Air Ambulance	Covered Up to 5 L	Covered Up to 5 L	Covered Up to 5 L	Covered Up to 5 L	Covered Up to 5 L
2	Daily Cash for Shared Room	Covered Rs. 800 per day max upto 4800	Covered Rs. 800 per day max upto 4800	Covered Rs. 1000 per day max up to 6000	Covered (India only) Rs. 800 per day max upto 4800	Covered (India only) Rs. 800 per day max upto 4800
3	Secure Benefit	Not Covered	Covered 100%	Covered 200%	Covered (India only) 100%	Covered (India only) 100%
4	Automatic Restore Benefit	Covered	Covered	Covered	Covered (India only)	Covered (India only)
5	Protect Benefit	Not Covered	Covered	Covered	Covered	Covered
6	Plus Benefit	Not Covered	Covered	Covered	Covered	Covered
7	**Aggregate Deductible	225k/50k/100k/ 200K/300K/ 5L/10L/20L/25L	25k/50k/100k/ 200K/300K/ 5L/10L/20L/25L	25k/50k/100k/ 200K/300K/ 5L/10L/20L/25L	25k/50k/100k/ 200K/300K/ 5L/10L/20L/25L (India only)	25k/50k/100k/ 200K/300K/ 5L/10L/20L/25L (India only)
8	E Opinion for Critical Illness	India	India	Global	Global	Global

	Plans	Optima Suraksha	Optima Secure	Optima Super Secure	Optima Secure Global	Optima Secure Global Plus
9	Global Health Cover (Emergency Treatments Only)	Not Covered	Not Covered	Not Covered	Covered (Outside India only)	Not Covered
10	Global Health Cover (Emergency & Planned Treatments)	Not Covered	Not Covered	Not Covered	Not Covered	Covered (Outside India only)
11	**Overseas Travel Secure	Not Covered	Not Covered	Not Covered	Covered (Outside India only)	Covered (Outside India only)
Wellbeing Cover						
1	Preventive Health Check-up	Defined Limits	Defined Limits	Defined Limits	Defined Limits (India only)	Defined Limits (India only)

Note: Optional Covers (except Aggregate Deductible & Overseas Travel Secure) are inbuilt in Plans as per the above table. Premium of such Optional covers are included in the premium of the respective Plan.

**Aggregate Deductible & Overseas Travel Secure are not an inbuilt feature in any of the above Plans. However, these covers can be separately opted at inception of the Policy or at subsequent Renewals. Aggregate Deductible if opted, shall apply only for claims arising in India. However, a Per Claim Deductible of Rs. 10,000 will apply separately for each and every claim arising out of India in Global plans. 5L / 10L Deductible can only be opted with Sum Insured >= 25 L

20L / 25L Deductible can only be opted with Sum Insured >= 50 L

^Claims shall be payable as per geography mentioned unless explicitly stated otherwise in a specific cover.

Preventive Health Check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.

Preventive Health Check-up, Secure Benefit, Cumulative Bonus / Plus Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force

Add on – Covers:

'my: Optima Secure' offers following Add on Covers:

- my: health Critical Illness Add On: Provides comprehensive coverage by offering a Lumpsum payout on diagnosis of any of the listed 51 critical Illnesses. Sum Insured options range from Rs. 100,000 to Rs. 500,00,000 in multiples of Rs. 100,000
- my: health Hospital Cash Benefit Add On: Per day hospital cash benefit for each continuous and completed 24 hours of hospitalization. Per day Sum Insured options of Rs. 500/ 1000/ 1500 / 2000/ 2500 / 3000 / 5000/ 7500/ 10,000 are available.
- Individual Personal Accident Rider: Provides Lumpsum pay out in case of Accidental Death, Permanent Total Disablement and Permanent Partial Disablement. Sum Insured shall be 5 (five) times the Sum Insured of Base Plan up to a maximum of Rs. 1 Crore
- Unlimited Restore (Add on): Provides unlimited restoration in a Policy Year.
- Optima Wellbeing (Add on) : Covers expenses for various outpatient benefits.

(For in depth details on terms and conditions applicable to add-ons, Kindly refer to the Prospectus & Policy wording documents of the respective add-on available under downloads section on our website).