HDFC ERGO General Insurance Company Limited
Prospectus

my:Optima Secure

my: Optima Secure is a unique indemnity health insurance product which covers expenses incurred on hospitalization due to Illness or Accident. Some of the innovative benefits offered are:

- Secure Benefit offers additional coverage amount equivalent to 100%/200% of the Base Sum Insured.
- Plus Benefit offers additional coverage equivalent to 100% of the Base Sum Insured in 2 years irrespective of a claim.
- Automatic Restore Benefits restores 100% of Base Sum Insured automatically on partial or complete utilization of Sum Insured (i.e. Base Sum Insured, Secure Benefit and Plus Benefit / Cumulative Bonus).
- Protect Benefit pays towards the Non-Medical expenses like gloves, food charges and other consumables during hospitalization.

1. Eligibility

- This Policy covers Insured Persons in the age group 91 days to 65 years.
- The minimum entry age for an adult is 18 years and maximum entry age is 65 years.
- The minimum entry age for a dependent child (i.e. natural or legally adopted) is 91 days and maximum entry age is 25 years.
- Dependent Child between 91 days and 5 years can be insured provided either of the parent is getting insured under this Policy.
- When the child attains the age of 25 years, he or she shall be ineligible for coverage in the subsequent renewals and will be migrated to a new Policy, with continuity benefits.
- There is no maximum cover ceasing age on renewals.
- The family includes following relationships: spouse, dependent children, parents and parents-in-law.
- In a family floater Policy, a maximum of 4 adults and a maximum of 6 dependent children can be included in a single Policy. The 4 adults can be a combination of self, spouse, parents and parents-in-law.
- In an individual Policy, a maximum of 6 adults and a maximum of 6 dependent children can be included in a single Policy.

2 Plans &Sum Insured (Rs.)

- my: Optima Secure offers three plans with following Sum Insured options depending on the Plan opted.

500,000	25,00,000
10,00,000	50,00,000
15,00,000	100,00,000
20,00,000	200,00,000

- All Insured Persons in a Policy will have the same Sum Insured.
- The Policy will be issued for a period of 1, 2 or 3 year(s), the Sum Insured and benefits will be applicable per Policy Year basis.

2.1 Illustration for maximum amount payable in a Hospitalization Claim (Rs.)

Year 1

Plan	Optima Suraksha	Optima Secure	Optima Super Secure
Base Sum Insured	10,00,000	10,00,000	10,00,000
Secure Benefit	NIL	10,00,000	20,00,000
Cumulative Bonus / Plus Benefit	NIL	NIL	NIL
Automatic Restore Benefit	10,00,000	10,00,000	10,00,000
Maximum permissible amount for a single Hospitalization claim in a Policy Year	10,00,000	20,00,000	30,00,000
Maximum permissible amount for all Hospitalization claims in a Policy Year	**20,00,000**	**30,00,000**	**40,00,000**

Year 2

Plan	Optima Suraksha	Optima Secure	Optima Super secure
Base Sum Insured	10,00,000	10,00,000	10,00,000
Secure Benefit	NIL	10,00,000	20,00,000
Cumulative Bonus* / Plus Benefit	100,000	500,000	500,000
Automatic Restore Benefit	10,00,000	10,00,000	10,00,000
Maximum permissible amount for a single Hospitalization claim in a Policy Year	11,00,000	25,00,000	35,00,000
Maximum permissible amount for all Hospitalization claims in a Policy Year	**21,00,000**	**35,00,000**	**45,00,000**

*Assuming No Claim in year 1

Year 3

Plan	Optima Suraksha	Optima Secure	Optima Super secure
Base Sum Insured	10,00,000	10,00,000	10,00,000
Secure Benefit	NIL	10,00,000	20,00,000
Cumulative Bonus* / Plus Benefit	200,000	10,00,000	10,00,000
Automatic Restore Benefit	10,00,000	10,00,000	10,00,000
Maximum permissible amount for a single Hospitalization claim in a Policy Year	12,00,000	30,00,000	40,00,000
Maximum permissible amount for all Hospitalization claims in a Policy Year	**22,00,000**	**40,00,000**	**50,00,000**

*Assuming No Claim in year 1 and 2

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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 4 and Section 5 below.

3.1 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 up to the Room Rent limit as specific in the Policy Schedule.
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.

3.1.1 Other Expenses

h. 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.
i. Dental Treatment, necessitated due to disease or Injury
j. Plastic surgery, necessitated due to Injury
k. All Day Care Treatments.

Note:

l. 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.
m. The Hospitalization must be for Medically Necessary Treatment, and prescribed in writing by Medical Practitioner.
n. In case of admission to a room of a higher category than mentioned herein, the reimbursement/payment of Room Rent charges including all Associated Medical Expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges.This condition is not applicable for Associated Medical Expenses in respect of Hospitals where differential billing for such Associated Medical Expenses is not followed based on Room Rent.

3.2 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 3.1 (Hospitalization Expenses).
b. The treatment is pre-authorized by the Company as per procedure given under Claims Procedure - Section 6.
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.

3.3 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.

3.4 AYUSH Treatment

The Company shall indemnify the Medical Expenses incurred by the Insured Person 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.

3.5 Pre-Hospitalization Expenses

The Company shall indemnify the Pre-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section 3.1 (Hospitalization Expenses), for up to 60 days immediately prior to the date of admissible Hospitalization covered under the Policy.

3.6 Post-Hospitalization Expenses

The Company shall indemnify the Post-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section 3.1 (Hospitalization Expenses), for up to 180 days from the date of discharge from the Hospital, following an admissible Hospitalization claim under the Policy.

3.7 Organ Donor Expenses

The Company shall indemnify the Medical Expenses covered under Section 3.1(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 3.1 (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.

3.8 Cumulative Bonus (CB)

Cumulative Bonus (CB) will be applied/increased by 10% of the Base Sum Insured in respect of each claim free Policy Year (where no claims are reported), provided the Policy is renewed with the Company without a break, subject to maximum cap of 100% of the Base Sum Insured under the current Policy Year. If a claim is made

in any particular Policy Year, the CB accrued shall be reduced at the same rate at which it has accrued.

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 if no claim has been reported. CB shall reduce only in case of claim from the same 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, provided no claim has been reported from any Family Member. CB shall reduce in case of claim from any of the Insured Persons.

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 a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any awarded CB shall be withdrawn.

i. 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.

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

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

4 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.

If the Policy is issued on an individual basis, each Insured Person can opt for any of the below optional covers as per his/her requirement, and if issued on a floater basis, the optional covers shall apply to all Insured Person(s) once selected, without any individual selection.

4.1 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 providefrom 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.

d. The Insured Person is in India and the treatment is taken in India 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 3.1 (Hospitalization Expenses).

4.2 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 Cover is 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 3.1 (Hospitalization Expenses).

4.3 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 3 (Base Coverage) during the Policy Year.

Exclusion (k) of Section7.2 – Specific Exclusions shall not apply to this Cover.

4.4 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 only once during each Policy Year, and once added, any amount unutilized in the current Policy Year will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy and such Plus Benefit not being completely exhausted.

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 3 (Base Coverage) and Section 4.3 (Protect Benefit) of the Policy.

Notes:

e. 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.

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

g. 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.

h. 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

i. 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.

j. 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.

k. 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.

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

4.5 Secure Benefit

An additional amount as specified in the Policy Schedule will be available to the Insured Personas Sum Insured for all claims admissible under Section 3 (Base Coverage)and Section 4.3 (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.

4.6 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 3 (Base Coverage) and Section 4.3 (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 the Insured Person.

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.

4.7 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 can be opted only at inception of the Policy or during subsequent Renewals.

b. Once the Aggregate Deductible option is opted by the Insured Person, it cannot be opted out or reduced at any time during the Policy Year or at subsequent Renewals.Deductible, however can be increased at the time of Renewal.

c. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted before the Company pays for claims of any Family Member covered under the Policy.

d. The Aggregate Deductible is not applicable to Sections 4.8(E-Opinion for Critical Illness), and 5.2 (Preventive Health Check Up).

e. All Insured Persons in a Policy will have the same Aggregate Deductible

4.8 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.

Disclaimer – E-Opinion for Critical Illness Services are being offered by Network Providers through its portal/mail/App or any other electronic form to the Policyholders/Insured Person. In no event shall the Company be liable for any direct, indirect, punitive, incidental, special,or consequential damages or any other damages whatsoever caused to the Policyholders/Insured Person while receiving the services from Network Providers or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Network Provider or treating Medical Practitioner.

Major Medical Illness			
1	Cancer of specified severity	27	Aplastic Anaemia
2	Open Chest CABG	28	Bacterial Meningitis
3	Kidney failure requiring regular dialysis	29	Cardiomyopathy
4	Myocardial Infarction (First Heart Attack of specified severity)	30	Other serious coronary artery disease
5	Open Heart Replacement or Repair of Heart Valves	31	Creutzfeldt-Jakob Disease (CJD)
6	Major Organ/Bone Marrow Transplantation	32	Encephalitis

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7	Multiple Sclerosis with persisting symptom	33	End Stage Lung Failure
8	Permanent Paralysis of Limbs	34	Fulminant Hepatitis
9	Stroke resulting in permanent symptoms	35	Eisenmenger's Syndrome
10	Benign Brain Tumour	36	Major Head Trauma
11	Coma of specified severity	37	Chronic Adrenal Insufficiency (Addison's Disease)
12	Parkinson's Disease	38	Progressive Scleroderma
13	Alzheimer's Disease	39	Progressive Supranuclear Palsy
14	Surgery of Aorta	40	Blindness
15	End Stage Liver Failure	41	Chronic Relapsing Pancreatitis
16	Deafness	42	Elephantiasis
17	Loss of Speech	43	Brain Surgery
18	Third Degree Burns	44	HIV due to blood transfusion and occupationally acquired HIV
19	Medullary Cystic Disease	45	Terminal Illness
20	Motor Neurone Disease with permanent symptoms	46	Myelofibrosis
21	Muscular Dystrophy	47	Pheochromocytoma
22	Infective Endocarditis	48	Crohn's Disease
23	Primary (Idiopathic) Pulmonary Hypertension	49	Severe Rheumatoid Arthritis
24	Dissecting Aortic Aneurysm	50	Severe Ulcerative Colitis
25	Systemic Lupus Erythematous with Lupus Nephritis	51	Angioplasty
26	Apallic Syndrome		

5. 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.

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

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

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

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

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

6. Add on – Cover

my:Optima Secure offers following Add on Covers:

- My: health Critical Illness Add On with Sum Insured options of Rs. 100,000 to Rs. 500,00,000 in multiples of Rs. 100,000
- My: health Hospital Cash Benefit Add On with Sum Insured options of Rs. 500/ Rs. 1000/ Rs. 1500 / Rs. 2000/ Rs. 2500 / Rs. 3000 / Rs. 5000/ Rs. 7500/ Rs. 10,000

  (Please refer the prospectus of the respective Add Ons for more details)

7. Pre Policy Check up

Pre-Policy Check-up at our network may be required based upon the age and basic sum insured.

- We will reimburse 100% of the expenses incurred per Insured Person on the acceptance of the proposal.
- If Proposal is declined post PPC, 100% of Medical test charges will be borne by the customer for Rs. 500,000 sum insured, 50% for Rs. 10,00,000 Sum Insured and NIL for other Sum Insureds.
- In case of any adverse medical declaration on the proposal form, we may request for additional medical tests.

8. Discounts

- Online Discount: The Insured Person is eligible for 5% discount on premium in case he / she purchase the Policy online from the Company's website or the Company's mobile app. The subsequent Renewal of the same Policy will continue to enjoy the 5% discount, provided the Policy remains without the involvement of any other insurance agent or insurance intermediary.
- Employee Discount: A discount of 5 % on the Premium is applicable if any Insured Person is a HDFC Group employee (full time employee) / Munich Re Group employee (full time employee) at the time of enrolment, or subsequent renewal; provided that such Policy is purchased through the Company's website or the Company's mobile app and without the involvement of any insurance agent or insurance intermediary.
- Loyalty Discount: If any Insured Person has an active retail insurance Policy with premium above Rs. 2,000 with the Company, a discount of 2.5% on the Policy premium will be applicable at the time of enrolment as well as subsequent renewals.
- Family Discount: The Insured Person will be entitled to receive 10% discount on the premium if two or more family members are covered under the same Policy under the individual Policy option.

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

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

declaration that they are based abroad in entirety for the Policy Year will be offered a discount of 40%, subject to the following conditions:

a. This is applicable in case the Insured's status is NRI for the whole year and he wishes to continue earning his PED coverage until upon his return. However, while in India if the Insured wishes to make a claim, he may do so by making the differential payment applicable on the policy.

b. For Insured who have been offered NRI discount in a particular policy year and at policy renewal makes further declaration of his stay abroad for the forthcoming year the applicable NRI discount would be offered on the renewal premium. If the Insured would be based in India then no discount would be applicable upon renewal.

c. For Insured who have been offered NRI discount in a particular policy year and he returns to India anytime during the year, the Insured can notify the Company about the change and make payment for the additional premium (equivalent to the applicable NRI discount). If the additional premium payment hasn't been made during the year, the same would be added to the renewal premium at the policy anniversary. The policy would be renewed subject to the full premium being received by the Company. In case of long term policies, the additional premium will be recovered only for the corresponding year and not from retrospective date.

- Aggregate Deductible Discount: If Aggregate Deductible is opted for all Insured Person, following discount will be applicable on the Policy premium.

Deductible Amount	Base Sum Insured less than equal to 20 Lakhs	Base Sum Insured above 20 Lakhs
25,000	25%	15%
50,000	40%	30%
100,000	50%	40%

9. Tax Benefit

Premium amount paid under this Policy qualifies for deduction under Section 80D of the Income Tax Act

10. 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:

10.1 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/treatmentsshall 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

Internal Congenital diseases	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
Pancreatitis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors
Cataract and other disorders of lens and Retina	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Osteoarthritis and osteoporosis	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

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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 type2 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.

10.2 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 Band 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.

11. Claims Procedure

11.1 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 3.2 (Home Health Care).

11.2 Procedure for Cashless Claims

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.

11.3 Procedure for Cashless Claims in case of Home Health Care (Section 3.2)

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.

11.4 Conditions for obtaining Cashless Facility

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

11.5 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.

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

Note:

t. The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.

u. 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.

v. 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.

w. 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.

12 Standard General Terms and Clauses

12.1 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

12.2 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.

12.3 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.

12.4 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.

12.5 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.

12.6 Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period

no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

12.7 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.

12.8 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 fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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.

12.9. Renewal of Policy:

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

a. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal
b. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years
c. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period
d. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period
e. No loading shall apply on renewals based on individual claims experience.

12.10 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

12.11 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

12.12 Cancellation

a. The Policyholder may cancel this Policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed below:

Month	1 Year	2 Year	3 Year
Up to 1 month	85.0%	92.5%	95.0%
Up to 3 month	70.0%	85.0%	90.0%
Up to 6 month	45.0%	70.0%	80.0%
Up to 12 month	0.0%	45.0%	65.0%
Up to 15 month	Not Applicable	30.0%	55.0%
Up to 18 month	Not Applicable	20.0%	45.0%
Up to 24 month	Not Applicable	0.0%	30.0%
Up to 27 month	Not Applicable	Not Applicable	20.0%
Up to 30 month	Not Applicable	Not Applicable	15.0%
Up to 36 month	Not Applicable	Not Applicable	0.0%

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

i. Where yearly payment option is in force under the Policy, cancellation grid as per 1-Year Tenure policies will be applicable.
ii. For all other payment options, 50% of current instalment premium will be refunded when the current period elapsed is less than 6 months from the commencement of the Policy Year. For instalment after 6 months, no refund will be payable.
iii. In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

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

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

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

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.

12.14 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 thefrequency 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.

12.15 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.

12.16 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

12.17 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.

12.18 Redressal of Grievance

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

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

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officerat cgo@hdfcergo.com

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

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

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://igms.irda.gov.in/.

13. Specific General Terms andClauses

13.1 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 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy

c. Levy underwriting loading from the first Policy Year of issuance of Policy or Renewal, whichever is later.

13.2 Utilization of Sum Insured

The sequence of utilization of the 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 Basic Sum Insured, Cumulative Bonus (if applicable), Plus Benefit (if applicable) and Secure Benefit (if applicable).

Illustration for Utilization of Sum Insured

- An Insured Person with Optima Secure Policy, Tenure 1 Year, Second Policy Year in progress, Base Sum Insured 5,00,000

Illustration 1

Number of Claim	Claim amount	Available Benefit Limit				Admissible claim amount	Utilisation of Sum Insured
		Base Sum Insured	Plus Benefit (on 1st renewal)	Secure Benefit	Automatic Restore Benefit		
1st claim	14,00,000	5,00,000	2,50,000	5,00,000	0	12,50,000	Base + Plus + Secure
2nd claim	3,00,000	-	-	-	5,00,000	3,00,000	Automatic Restore (partial)
3rd claim	3,00,000	-	-	-	2,00,000	2,00,000	Automatic Restore (balance)

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Illustration 2

Number of Claim	Claim amount	Available Benefit Limit				Admissible claim amount	Utilisation of Sum Insured
		Base Sum Insured	Plus Benefit (on 1st renewal)	Secure Benefit	Automatic Restore Benefit		
1st claim	3,00,000	5,00,000	2,50,000	5,00,000	0	3,00,000	Base (partial)
2nd claim	14,00,000	2,00,000	2,50,000	5,00,000	3,00,000	12,50,000*	Base (balance) + Plus + Secure + Automatic Restore (partial)
3rd claim	3,00,000	-	-	-	2,00,000	2,00,000	Automatic Restore (partial)

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

Illustration 3

Number of Claim	Claim amount	Available Benefit Limit				Admissible claim amount	Utilisation of Sum Insured
		Base Sum Insured	Plus Benefit (on 1st renewal)	Secure Benefit	Automatic Restore Benefit		
1st claim	3,00,000	5,00,000	2,50,000	5,00,000	0	3,00,000	Base (partial)
2nd claim	10,00,000	2,00,000	2,50,000	5,00,000	3,00,000	10,00,000	Base (balance) + Plus + Secure + Automatic Restore (partial)
3rd claim	3,00,000	-	-	-	4,50,000	3,00,000	Automatic Restore (partial)

13.3 Geography

This Policy provides coverage throughout the territory of India, except under Section 4.8 (E-Opinion for Critical Illness) as applicable.

13.4 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.

13.5 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.

13.6 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.

14 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.

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14 Premium Computation Illustration

Illustration 1

- Plan Name – Optima Secure
- Tenure – 1 Year
- Location – Delhi - Tier 1

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of 10% (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater discount of 55% applied on all the members except the oldest member	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
5	8,500	10	8,500	850	7,650	10	8,500	4,675	3,825	10
25	12,500	10	12,500	1,250	11,250	10	12,500	6,875	5,625	10
35	14,500	10	14,500	1,450	13,050	10	14,500	7,975	6,525	10
45	16,500	10	16,500	1,650	14,850	10	16,500	9,075	7,425	10
55	32,500	10	32,500	3,250	29,250	10	32,500	17,875	14,625	10
65	58,000	10	58,000	5,800	52,200	10	58,000	0	58,000	10
	1,42,500				**1,28,250**				**96,025**	
	Total premium for all members of the family is Rs. 1,42,500, when each member is covered separately. Sum Insured available for each individual is Rs. 10 Lakhs.		Total premium for all members of the family is Rs. 1,28,250, when they are covered under a single policy. Sum Insured available for each individual is Rs. 10 Lakhs				Total premium when policy is opted on floater basis is Rs. 96,025. Sum Insured of Rs. 10 Lakhs is available for the entire family			

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Illustration 2

- Plan Name – Optima Secure
- Tenure – 1 Year
- Location – Delhi - Tier 1

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of 10% (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater discount of 55% applied on all the members except the oldest member	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
10	9,500	10	9,500	950	8,550	10	9,500	5,225	4,275	10
24	12,300	10	12,300	1,230	11,070	10	12,300	6,765	5,535	10
45	16,500	10	16,500	1,650	14,850	10	16,500	9,075	7,425	10
55	32,500	10	32,500	3,250	29,250	10	32,500	17,875	14,625	10
65	58,000	10	58,000	5,800	52,200	10	58,000	31,900	26,100	10
75	93,000	10	93,000	9,300	83,700	10	93,000	0	93,000	10
	2,21,800				**1,99,620**				**1,50,960**	
	Total premium for all members of the family is Rs. 2,21,800, when each member is covered separately. Sum Insured available for each individual is Rs. 10 Lakhs.		Total premium for all members of the family is Rs. 1,99,620, when they are covered under a single policy. Sum Insured available for each individual is Rs. 10 Lakhs				Total premium when policy is opted on floater basis is Rs. 1,50,960. Sum Insured of Rs. 10 Lakhs is available for the entire family			

Section 41 of Insurance Act 1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees

IRDAI Regulation no 5- This Policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation
Disclaimer: the above is descriptive only. The actual terms and conditions can be found in the policy document. Insured's are advised to read the policy document completely for a full description of the terms and conditions of coverage and the exclusions relating thereto.
Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI.

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Annexure A – Schedule of Benefits

Section*	Plans	Optima Suraksha		Optima Secure		Optima Super Secure	
All figures in Rs	Base Sum Insured per Insured Person per Policy Year (in Lakh)	5/10/15/20/25/50		5/10/15/20/25/50/100/200		10/15/20/25/50/100/200	
3.1	Hospitalization Expenses	Covered		Covered		Covered	
3.1	Room Rent	Single AC Private Room for SI less than 50 Lakhs	Actuals for 50 Lakh	Single AC Private Room for SI less than 50 Lakhs	Actuals for 50 Lakh and above	Single AC Private Room for SI less than 50 Lakhs	Actuals for 50 Lakh and above
3.1.1.a.	Road Ambulance	Covered		Covered		Covered	
3.1.1.b.	Dental Treatment	Covered		Covered		Covered	
3.1.1.c.	Plastic Surgery	Covered		Covered		Covered	
3.1.1.d.	Day Care Treatment	Covered		Covered		Covered	
3.2	Home Healthcare	Covered		Covered		Covered	
3.3	Domiciliary Hospitalization	Covered		Covered		Covered	
3.4	AYUSH Treatment	Covered		Covered		Covered	
3.5	Pre-Hospitalization	60 days		60 days		60 days	
3.6	Post-Hospitalization	180 days		180 days		180 days	
3.7	Organ Donor Expenses	Covered		Covered		Covered	
3.8	Cumulative Bonus	Bonus of 10% of the Base Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 10% of the Base Sum Insured at renewal		Not Covered		Not Covered	
4.1	Emergency Air Ambulance	500,000		500,000		500,000	
4.2	Daily Cash for choosing Shared Accommodation	800 per day max up to 4800		800 per day max up to 4800		1000 per day max up to 6000	
4.3	Protect Benefit	Not Covered		Covered upto Sum Insured		Covered upto Sum Insured	
4.4	Plus Benefit	Not Covered		Bonus of 50% of the Base Sum Insured, maximum upto 100%		Bonus of 50% of the Base Sum Insured, maximum upto 100%	
4.5	Secure Benefit	Not Covered		Equal to 100% of Base Sum Insured		Equal to 200% of Base Sum Insured	
4.6	Automatic Restore Benefit	Equal to 100% of Base Sum Insured		Equal to 100% of Base Sum Insured		Equal to 100% of Base Sum Insured	
4.7	Aggregate Deductible (Optional)	25,000/50,000/1,00,000		25,000/50,000/1,00,000		25,000/50,000/1,00,000	
4.8	E-Opinion for Critical Illness	In India		In India		Global	
5	Preventive Health Check-up						
	Sum Insured	5 Lakhs	10 Lakhs	15 Lakhs	20,25 & 50 Lakhs	100 & 200 Lakhs	
	Individual Policy*	1,500	2,000	4,000	5,000	8,000	
	Floater Policy*	2,500	5,000	8,000	10,000	15,000	

*For Individual policy sum insured and limits mentioned in the table are applicable on per Insured Person per Policy Year basis and for Family Floater policy sum insured and limits apply on per policy per Policy Year basis

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Annexure B - List I – Items for which coverage is not available in the policy (Non-Medical Expenses)

Sl 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 The Hospital)
36	Spacer
37	Spirometre
38	Nebulizer Kit
39	Steam Inhaler

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Sl No	Item
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, Orthokit, Recovery Kit, etc.]
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety

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