**Optima Restore, Customer Information Sheet**

**HDFC ERGO Health Insurance Limited**

Description is illustrative and not exhaustive

<table>
<thead>
<tr>
<th>TITLE</th>
<th>DESCRIPTION</th>
<th>REFER TO POLICY CLAUSE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Name</td>
<td>Optima Restore</td>
<td></td>
</tr>
<tr>
<td>What am I covered for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. In-patient Treatment</td>
<td>Covers hospitalisation expenses for period more than 24 hrs.</td>
<td>Section 1.1 a)</td>
</tr>
<tr>
<td>b. Pre-Hospitalisation</td>
<td>Medical expenses incurred in 60 days before the hospitalisation.</td>
<td>Section 1.1 b)</td>
</tr>
<tr>
<td>c. Post-Hospitalisation</td>
<td>Medical expenses incurred in 180 days after the hospitalisation.</td>
<td>Section 1.1 c)</td>
</tr>
<tr>
<td>d. Day-Care procedures</td>
<td>Medical expenses for day care procedures.</td>
<td>Section 1.1 d)</td>
</tr>
<tr>
<td>e. Domiciliary Treatment</td>
<td>Medical expenses incurred for availing medical treatment at home which would otherwise have required hospitalisation.</td>
<td>Section 1.1 e)</td>
</tr>
<tr>
<td>f. Organ Donor</td>
<td>Medical expenses on harvesting the organ from the donor for organ transplantation.</td>
<td>Section 1.1 f)</td>
</tr>
<tr>
<td>g. Ambulance cover</td>
<td>Upto Rs. 2,000 per hospitalisation for utilizing ambulance service for transporting insured person to hospital in case of an emergency.</td>
<td>Section 1.1 g)</td>
</tr>
<tr>
<td>h. Daily Cash for choosing shared accommodation</td>
<td>Daily cash amount if hospitalised in shared accommodation in network hospital and hospitalisation exceeds 48 hrs</td>
<td>Section 1.1 h)</td>
</tr>
<tr>
<td>i. E-Opinion in respect of a Critical Illness</td>
<td>Second opinion by a Medical Practitioner from Our panel, for a Critical Illness suffered during the policy period.</td>
<td>Section 1.1 i)</td>
</tr>
<tr>
<td>j. Emergency Air Ambulance Cover</td>
<td>covers, Expenses for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions.</td>
<td>Section 1.1 j)</td>
</tr>
<tr>
<td>k. Restore Benefit</td>
<td>Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Multiplier Benefit (if applicable) during the Policy Year. The Restore Sum Insured can be used for all claims under Inpatient Benefit. If the Restore Sum Insured is not utilized in a Policy Year, it will expire.</td>
<td>Section 2)</td>
</tr>
<tr>
<td>What are the major exclusions in the policy:</td>
<td>Following is a partial list of the policy exclusions. Please refer to the policy wording for the complete list of exclusions.</td>
<td>Section 5 c)</td>
</tr>
<tr>
<td>War or any act of war, nuclear, chemical and biological weapons, radiation of any kind, breach of law with criminal intent, intentional or attempted suicide, 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, treatment for alcoholism, drug or substance abuse or any addictive condition, treatment of obesity and any weight control program, sleep apnoea, external congenital illness, sterility, treatment to effect or to treat infertility, circumcision, treatment for correction of refractive error, plastic surgery or cosmetic surgery unless required due to an Accident, Cancer or Burns, any non-allopathic treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 30 days for all illnesses (except accident) in the first year and is not applicable in subsequent renewals</td>
<td>Section 5.a i)</td>
<td></td>
</tr>
<tr>
<td>• 24 months for specific illness and treatments in the first two years and is not applicable in subsequent renewals</td>
<td>Section 5.a ii)</td>
<td></td>
</tr>
<tr>
<td>• Pre-existing Diseases will be covered after a waiting period 36 months.</td>
<td>Section 5.a iii)</td>
<td></td>
</tr>
<tr>
<td>Payout basis</td>
<td>Payout on indemnity payment basis.</td>
<td>Section 1</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Renewal Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Policy is ordinarily life-long renewable, subject to application for renewal and the renewal premium in full has been received by the due dates and realisation of premium.</td>
<td>Section 6. n )</td>
<td></td>
</tr>
<tr>
<td>• Grace period of 30 days for renewing the policy is provided. To avoid any confusion any claim incurred during break-in period will not be payable under this policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renewal Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiplier Benefit – 50% increase in your basic sum insured for every claim free year, subject to a maximum of 100%. In case a claim is made during a policy year, the limit under this benefit would be reduced by 50% of the basic sum insured in the following year. However this reduction will not reduce the Sum Insured below the basic Sum Insured of the policy.</td>
<td>Section 4</td>
<td></td>
</tr>
<tr>
<td>• Preventive Health Check-up – we will reimburse upto the stated amount towards cost incurred in the preventive health check-up.</td>
<td>Section 3</td>
<td></td>
</tr>
<tr>
<td>• Stay Active- Upto 8% discount on renewal premium subject to insured member achieving the average number of steps in each time interval prescribed in the grid by either walking or running regularly to keep fit. The discount will be accrued by the customer at defined time intervals and cumulated at the end of the policy period and offered as a discount on renewal premium.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancellation</td>
<td>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.</td>
<td>Section 6. r)</td>
</tr>
</tbody>
</table>
## How to Claim
Please contact Us at least 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact Us within 24 hours of the event. For any claim related query, information or assistance You can also contact Our Toll Free Line at 1800-102-0333 or visit Our website www.hdfcergohealth.com or e-mail Us at customerservice@hdfcergohealth.com

## Section 8
### Insured's Rights
- **Free Look:** You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium.

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
- **Claims**
  - For Cashless Claims: We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents.
  - For Reimbursement Claims: On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days.

### Insured's Obligations
Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.

Disclosure of material facts sought to be declared on the proposal form.

Note:
- 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 on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Check-up.
- In order to be eligible for portability benefits you may apply 45 days in advance of the policy renewal date.

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the Key featured document and the policy document the terms and conditions mentioned in the policy document shall prevail.
HDFC ERGO Health Insurance Limited will cover all the Insured Persons under this Policy upto the Sum Insured. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

### Section I. Inpatient Benefits
This section of benefits is applicable when
- An insured suffers an Accident or Illness, which is covered under this Policy
- Hospitalisation is necessary & is done for treatment OR
- Day care treatment is necessary and is done OR
- Domiciliary treatment is necessary and is done

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

<table>
<thead>
<tr>
<th>We will cover the Medical Expenses for:</th>
<th>In addition to the waiting periods (Section 5a) and general exclusions (Section 5c), We will also not cover expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a. In-patient Treatment. This includes: • Hospital room rent or boarding; • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anaesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs &amp; consumables; • Diagnostic procedures.</td>
<td>If as per any or all of the Medical references herein below containing guidelines and protocols for Evidence Based Medicines, the Hospitalisation for treatment under claim is not necessary or the stay at the hospital is found unduly long: • Medical text books, • Standard treatment guidelines as stated in clinical establishment act of Government of India, • World Health Organisation (WHO) protocols, • Published guidelines by healthcare providers, • Guidelines set by medical societies like cardiological society of India, neurological society of India etc.</td>
</tr>
<tr>
<td>b. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital (In-patient OR Day Care OR Domiciliary treatment).</td>
<td>i) Claims which have NOT been admitted under 1a) and 1d). ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.</td>
</tr>
<tr>
<td>c. Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 180 days after discharge from the Hospital (In-patient OR Day Care OR Domiciliary treatment).</td>
<td>i) Claims which have NOT been admitted under 1a) and 1d). ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.</td>
</tr>
<tr>
<td>d. Day Care Procedures Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours. Treatment normally taken on out-patient basis is not included in the scope of this definition.</td>
<td>i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) Treatment NOT taken at a Hospital or Day-care centre.</td>
</tr>
<tr>
<td>e. Domiciliary Treatment Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii. The patient takes treatment at home on account of non availability of room in a Hospital. ii. Pre and Post Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation and 180 days after hospitalisation respectively will be covered in case of domiciliary treatment.</td>
<td>1. Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days only if treatment period is greater than three days).</td>
</tr>
<tr>
<td>f. Organ Donor Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an insured person while donating an organ is NOT covered.</td>
<td>1. Claims which have NOT been admitted under 1a) for insured member. 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor’s Pre and Post-Hospitalisation expenses.</td>
</tr>
<tr>
<td>g. Ambulance Cover Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to Rs. 2000 per Hospitalisation.</td>
<td>1. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 2. Claims which have NOT been admitted under 1a).</td>
</tr>
<tr>
<td>h. Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as mentioned in schedule of benefits if the Insured Person is hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.</td>
<td>1. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 2. Claims which have NOT been admitted under 1a).</td>
</tr>
</tbody>
</table>
i. E-Opinion in respect of a Critical Illness

We shall arrange and pay for a second opinion from Our panel of medical Practitioners, if:
- The Insured Person suffers a Critical Illness during the Policy Period; and
- He requests an E-opinion; and
The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner.

“Critical Illness” includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke.

1. More than one claim for this benefit in a Policy Year.
2. Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.

j. Emergency Air Ambulance Cover

We will pay for ambulance transportation in an airplane or helicopter subject to maximum limit prescribed in j (1), for emergency life threatening health conditions which require immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide subject to:
- Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency;
- The Medical Evacuation been prescribed by a Medical Practitioner and is Medically Necessary;
- The insured person is in India and the treatment is required in India only and not overseas in any condition whatsoever; and
- The air ambulance provider being registered in India.

J(i) The amount payable in case of Air ambulance facility shall be either the actual expenses or Rs. 2.5 Lacs per hospitalisation, whichever is lower; up to basic sum insured limit for a year.

1. Claims which have NOT been admitted under 1 a) and 1d).
2. Expenses incurred in return transportation to the insured’s home by air ambulance is excluded.

Section 2. Restore Benefits.

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

Conditions for Restore benefit:
- a. The Sum Insured will be restored only once in a Policy Year.
- b. If the Restored Sum Insured is not utilized in a Policy Year, it will expire.
In case of a Family Floater Policy, Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.

Important terms you should know

<table>
<thead>
<tr>
<th>Important terms You should know.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sum Insured</strong> means** the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Period.**</td>
</tr>
<tr>
<td><strong>In-patient Care means</strong> treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.</td>
</tr>
<tr>
<td><strong>Out-patient Treatment means</strong> the medical consultation, investigations or treatment taken in a clinic / hospital or associated facility like a consultation room. Important to note that out-patient treatment does not require admission to day care or in-patient sections of hospital.</td>
</tr>
<tr>
<td><strong>Medical Practitioner means</strong> a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. And is NOT a member of the Insured Person’s family or stays with him.</td>
</tr>
<tr>
<td><strong>Shared accommodation means</strong> a Hospital room with two or more patient beds.</td>
</tr>
<tr>
<td><strong>Single occupancy or any higher accommodation n type means</strong> a Hospital room with only one patient bed.</td>
</tr>
</tbody>
</table>
Section 3. Preventive Health Checkup
This benefit is effective only if mentioned in the schedule of benefits.

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

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

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

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

Section 4. Multiplier Benefit

a) If NO claims have been made in respect of any benefit listed under Section 1 in a Policy Year and the Policy is renewed with Us without any break
i) We will apply a bonus by enhancing the renewed policy’s Sum Insured by 50% of the Basic Sum Insured of the previous year’s Policy.
ii) The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

In Family Floater policy,
1. The Multiplier Benefit shall be available on Family Floater basis and accrue only if no claims have been made in respect of any Insured Person during the previous Policy Year.
2. Accrued Multiplier Benefit is available to all Insured Persons under the Policy.

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

c) If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the multiplier bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the multiplier bonus to be carried forward for credit in the Policy would be the lowest accrued multiplier bonus amongst all the Insured Persons from the expiring Policy.

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

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

Section 5. Special terms and conditions

A) Waiting Periods
All Illnesses and treatments shall be covered subject to the waiting periods specified below:

i. 30-day waiting period – Code – Excl03
   a) Expenses related to the treatment of any illness within 30 days of the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b) This exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.
   c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified disease/procedure waiting period – Code – Excl02
   a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident or underlying cause is cancer(s).

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

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

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

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

f) List of specific diseases/procedures:

<table>
<thead>
<tr>
<th>Organ / Organ System</th>
<th>Illness / diagnoses (irrespective of treatments medical or surgical)</th>
<th>Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>• Sinusitis • Rhinitis • Tonsillitis</td>
<td>• Adenoiectomy • Mastoiectomy • Tonsillectomy • Tympanoplasty • Surgery for Nasal septum deviation • Surgery for Turbin ate hypertrophy • Nasal concha resection • Nasal polypectomy</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>• Cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomiosis • Endometrosis • Prolapsed Uterus</td>
<td>• Hysterectiony</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>• Non infective arthritis • Gout and Rheumatism • Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk</td>
<td>• Joint replacement surgeries</td>
</tr>
</tbody>
</table>
Gastrointestinal

- Cholelithiasis
- Cholecystitis
- Pancreatitis
- Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus
- Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum
- Cirrhosis (However Alcoholic cirrhosis is permanently excluded)
- Perineal and Perianal Abscess
- Rectal Prolapse

- Cholecystectomy
- Surgery of hernia

Urogenital

- Calculus diseases of Urogenital system including Kidney, ureter, bladder stones
- Benign Hyperplasia of prostate
- Varicoceles

- Surgery on prostate
- Surgery for Hydrocele/ Retecele

Eye

- Cataract
- Retinal detachment
- Glaucoma

Nil

Others

Nil

General (Applicable to all organ systems/ organs whether or not described above)

- Benign tumors of Non infectious etiology eg. cysts, nodules, polyps, lump, growth, etc

- NIL

Organ / Organ System | Illness / diagnoses (irrespective of treatments medical or surgical) | Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)
--- | --- | ---
Gastrointestinal | Cholelithiasis, Cholecystitis, Pancreatitis, Fistula/fistula in anus, Haemorrhoids, Pilonidal Sinus, Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum, Cirrhosis (However Alcoholic cirrhosis is permanently excluded), Perineal and Perianal Abscess, Rectal Prolapse | Cholecystectomy, Surgery of hernia
Urogenital | Calculus diseases of Urogenital system including Kidney, ureter, bladder stones, Benign Hyperplasia of prostate, Varicocele | Surgery on prostate, Surgery for Hydrocele/Retecele
Eye | Cataract, Retinal detachment, Glaucoma | Nil
Others | Nil | Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/ organs whether or not described above) | Benign tumors of Non infectious etiology eg. cysts, nodules, polyps, lump, growth, etc | NIL

### Medical Exclusions

1. **Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.**

2. **Unproven Treatments:**

   - Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. Code – Excl016

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

4. **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, mountainwering, rafting, motor racing, horse racing or scuba diving, hang gliding, ski diving, deep-sea diving.

5. **Pre-Existing Diseases – Code – Excl01**
   a. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increased.
   c. If the insured person is continuously covered without any break as defined under the portability/migration norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
   d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

6. **General exclusions:**

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

### Non Medical Exclusions

1. **War or similar situations:**

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

2. **Intentional self-injury or attempted suicide.**

3. **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.
Optima Restore, Policy Wording
HDFC ERGO Health Insurance Limited

21. 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
22. 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
23. Sleep-apnoea
24. External congenital diseases, defects or anomalies
25. Growth hormone therapy
26. 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.
27. 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
28. Dental treatment and surgery of any kind, unless requiring Hospitalisation.
29. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the
   Schedule and accepted by the insured.
30. Any non-medical expenses mentioned in Annexure I.
31. Any type of contraception, sterilization
32. 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.
33. Treatment rendered by a Medical Practitioner which is outside his discipline or the
   discipline for which he is licensed.
34. Treatments rendered by a Medical Practitioner who is a member of the Insured Person’s
   family or stays with him, however proven material costs are eligible for reimbursement
   in accordance with the applicable cover.
35. Any treatment or part of a treatment that is not of a reasonable charge and not Medically
   Necessary.
36. Drugs or treatments which are not supported by a prescription.
37. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the
   Schedule and accepted by the insured.
38. Admission for administration of Intra-articular or Intra-lesional injections, Supplementary
   medications like Zoledronic acid (Trade name Zometa, Reclast, etc) or IV
   immunoglobulin infusion

Section VI. General Conditions
a. Condition Precedent to admission of Liability
   The terms and conditions of the Policy must be fulfilled by the Insured Person for the
   Company to make any payment for claim(s) arising under the Policy.

b. Geography
   This Policy only covers medical treatment taken within India. All payments under
   this Policy will only be made in Indian Rupees within India. For the purpose of policy
   issuance, the premium will be computed basis the city of residence provided by the
   insured person in the proposal form. The premium that would be applicable zone wise
   and the cities defined in each zone are as under:
   • Delhi NCR/Mumbai MMR- Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater
     Noida ,Mumbai, Navi Mumbai , Thane, Kalyan, Dombivali, Bhayander, Ulhasnagar,
     Bhiwandi, Vasai,Virar
   • Rest of India- All other cities
   • The premium will be modified in case of mid term address change involving migration
     from one zone to another and would be calculated on pro-rata basis.

c. Insured Person
   Only those persons named as Insured Persons in the Schedule shall be covered
   under this Policy. Any eligible person may be added during the Policy Period after
   his application has been accepted by Us and additional premium has been received.
   Insurance cover for this person shall only commence once We have issued an
   endorsement confirming the addition of such person as an Insured Person.
   Any Insured Person in the policy has the option to migrate to similar indemnity health
   insurance policy available with us at the time of renewal subject to underwriting with all
   the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc.
   provided the policy has been maintained without a break as per portability/migration
   guidelines.
   If an Insured Person dies, he will cease to be an Insured Person upon Us receiving
   all relevant particulars in this regard. We will return a rateable part of the premium
   received for such person IF AND ONLY IF there are no claims in respect of that Insured
   Person under the Policy

d. Loadings & Discounts
   We may apply a risk loading on the premium payable (based upon the declarations
   made in the proposal form and the health status of the persons proposed for
   insurance). The maximum risk loading applicable for an individual shall not exceed
   above 100% per diagnosis / medical condition and an overall risk loading of over 150%
   per person. These loadings are applied from Commencement Date of the Policy
   including subsequent renewal(s) with Us or on the receipt of the request of increase in
   Sum Insured (for the increased Sum Insured).
   We will inform You about the applicable risk loading or exclusion or both as the case
   may be through a counter offer letter. You need to revert to Us with consent and
   additional premium (if any), within 7 days of the receipt of such counter offer letter.
   In case, you neither accept the counter offer nor revert to Us within 7days, We shall
   cancel Your application and refund the premium paid within next 7 days. We will issue
   Policy only after getting Your consent and additional premium (if any). Please visit our
   nearest branch to refer our underwriting guidelines if required.
   We will provide a Family Discount of 10% if 2 or more family members are covered
   e family members are covered under a single Optima Restore Policy. Any additional
   discount of 7.5% will be provided if insured person is paying two year premium in
   advance as a single premium. These discounts shall be applicable at inception and
   renewal of the policy.
   PI Note: The application of loading does not mean that the illness/ condition, for which
   loading has been applied, would be covered from inception. Any waiting period as
   mentioned in Section 5 a ) (i), (ii) & (iii) above or specifically mentioned on the Policy
   Schedule shall be applied on illness/condition, as applicable.

Stay Active
We will offer a discount at each renewal if the insured member achieves the average
step count target on the mobile application provided by Us in the specified time interval
(calculated from the policy risk start date) as per the grid below. In an individual policy,
the average step count would be calculated per adult member and in a floater policy it
would be an average of all adult members covered. Dependent children covered either
in individual or floater plan will not be considered for calculation of average steps.
This discount will be accrued at defined time intervals as given in table below. The
discount will be cumulated and offered as discount on the renewal premium.
In individual policies the discount percentage (%) would be applied on premium
applicable per insured member (Dependent Children are not eligible for this stay active
discount in an individual policy) and in a floater policy it would be applied on premium
applicable on policy.
Optima Restore, Policy Wording
HDFC ERGO Health Insurance Limited

The discount grid would be as per the table below:

### 1 Year Policy

<table>
<thead>
<tr>
<th>Average Step Target</th>
<th>Risk start date or date of download of mobile application -90 days</th>
<th>91-180 days</th>
<th>181-270 days</th>
<th>271-300 days</th>
<th>Maximum Discount at the end of the year</th>
</tr>
</thead>
<tbody>
<tr>
<td>5000 or below</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>5001 to 8000</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>2%</td>
</tr>
<tr>
<td>8001 to 10000</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>5%</td>
</tr>
<tr>
<td>Above 10000</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>8%</td>
</tr>
</tbody>
</table>

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

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

**Illustration**

<table>
<thead>
<tr>
<th>Policy start date</th>
<th>1st Jan 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Tenure</td>
<td>1 year</td>
</tr>
</tbody>
</table>

### Time Interval

<table>
<thead>
<tr>
<th>Risk start date or date of download of mobile application -90 days</th>
<th>91 days-180 days</th>
<th>181 days-270 days</th>
<th>271-300 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average steps taken in the defined time period</td>
<td>8500</td>
<td>10000</td>
<td>5001</td>
</tr>
<tr>
<td>Discount % applicable</td>
<td>1.25%</td>
<td>1.25%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Total discount applicable on renewal premium = 3.5%

**e. Notification of Claim**

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

### f. Cashless Service:

<table>
<thead>
<tr>
<th>Treatment, Consultation or Procedure:</th>
<th>Treatment, Consultation or Procedure Taken at:</th>
<th>Cashless Service is Available:</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) If any planned treatment, consultation or procedure for which a claim may be made:</td>
<td>Network Hospital</td>
<td>We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.</td>
</tr>
<tr>
<td>ii) If any treatment, consultation or procedure for which a claim may be made is to be taken in an Emergency:</td>
<td>Network Hospital</td>
<td>We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.</td>
</tr>
</tbody>
</table>

**g. Supporting Documentation & Examination**

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

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

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

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

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

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

vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor’s invoice.
i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, willfully or otherwise, the Policy shall be:

• cancelled ab initio from the inception date or the renewal date (as the case may be), or
• the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule and
• the claim under such Policy if any, shall be rejected/reputed forthwith.

i. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

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

c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later;

The above options will not prejudice the rights of the Company to invoke cancellation under clause i above.

k. Fraud

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

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

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

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

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

c) any other act fitted to deceive; and

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

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

l. Multiple Policies

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

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

iii. If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured Person has policies from more than one Insurer to cover the same disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

m. Endorsements

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

n. Renewal of Policy

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

i. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim for the first time.
or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

o. Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person’s immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

p. Notices

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

i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement

ii) Us, shall be delivered to Our address specified in the Schedule.

iii) No insurance agents, brokers, other person/entity is authorised to receive any notice on Our behalf.

q. 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

r. Cancellation

i. 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.

<table>
<thead>
<tr>
<th>Length of time Policy in force</th>
<th>Refund of premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 1 Month</td>
<td>75.00%</td>
</tr>
<tr>
<td>Upto 3 Months</td>
<td>50.00%</td>
</tr>
<tr>
<td>Upto 6 Months</td>
<td>25.00%</td>
</tr>
<tr>
<td>Exceeding 6 Months</td>
<td>Nil</td>
</tr>
</tbody>
</table>

ii. 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.

s. Free Look Period

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

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

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

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

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

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

Disclosures 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.

u. 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.

v. 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.

w. 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.


x. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company for applying for Migration of the policy at least 30 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.


y. 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.

z. Withdrawal of Policy

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

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

aa. 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.

C) Other Important Terms You should know

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

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

Def. 2. 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. 3. Age or Aged means completed years as at the Commencement Date.

Def. 4. Alternative treatments means forms of treatments other than treatment “Allopathy” or “modern medicine” and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.
Def. 5. 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. 6. Bank Rate means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 7. 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. 8. Commencement Date means the commencement date of this Policy as specified in the Schedule.

Def. 9. Condition Precedent means a policy term or condition upon which the Insurer’s liability under the policy is conditional upon.

Def. 10. 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. 11. Contribution means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def. 12. 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. 13. Cumulative Bonus (Multiplier Benefit) means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 14. Critical Illness means Cancer of specified severity, Open Chest CABG, Myocardial Infarction (First Heart Attack of Specified Severity), Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with persisting symptoms, Permanent Paralysis of Limbs, Stroke resulting in permanent symptoms as defined below:

I. Cancer Of Specified Severity

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaT1N0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

II. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

III. Myocardial Infarction (First Heart Attack of Specified Severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

IV. Kidney Failure Requiring Regular Dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

V. Major Organ/ Bone Marrow Transplant:

I. The actual undergoing of a transplant of:

i. One of the following human organs - heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ;

ii. Human bone marrow using haematopoietic stem cells.

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

II. The following are excluded:

i. Other Stem-cell transplants

ii. Where only islets of langerhans are transplanted

VI. Multiple Sclerosis with Persisting Symptoms:

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

VII. Permanent Paralysis of Limbs

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

VIII. Stroke Resulting in Permanent Symptoms

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

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

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

The following are excluded:

i. Transient ischemic attacks (TIA)
Def. 25. Grace Period means the specified period of time immediately following the
coverage of Pre-Existing Diseases. Coverage is not available for the period for
which no premium is received.

Def. 26. Hospital means any institution established for in-patient care and day care
treatment of illness and/or injuries and which has been registered as a hospital
with the local authorities under the Clinical Establishments (Registration and
Regulation) Act, 2010 or under the enactments specified under the Schedule of
Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

Def. 28. Illness means a sickness or a disease or pathological condition leading to the
impairment of normal physiological function and requires medical treatment.

I. Acute condition - Acute condition is a disease, illness or injury that is
likely to respond quickly to treatment which aims to return the person to
his or her state of health immediately before suffering the disease/illness/
injury which leads to full recovery

II. Chronic condition - A chronic condition is defined as a disease, illness, or
injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations,
   examinations, check-ups, and/or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be
    specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

Def. 29. Injury means accidental physical bodily harm excluding illness or disease
solely and directly caused by external, violent, visible and evident means which is
verified and certified by a Medical Practitioner.

Def. 30. 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. 31. Insured Person means You and the persons named in the Schedule.

Def. 32. Intensive Care Unit means an identified section, ward or wing of a hospital
which no premium is received.

Def. 33. 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. 34. 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. 35. Maternity expenses means

I. medical treatment expenses traceable to childbirth (including complicated
deliveries and caesarean sections incurred during hospitalization);
II. expenses towards lawful medical termination of pregnancy during the
    policy period.

Def. 36. Medical Advise means any consultation or advice from a Medical Practitioner
including the issuance of any prescription or follow-up prescription

Def. 37. 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. 38. Medically Necessary Treatment means any treatment, test, medication, or
stay in Hospital or part of stay in Hospital which

Def. 15. Day Care Centre means any institution established for day care treatment
of illness and/or injuries or a medical setup with a hospital and which has
been registered with the local authorities, wherever applicable, and is under
supervision of a registered and qualified medical practitioner AND must comply
with all minimum criterion as under –

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

Def. 17. Day Care Treatment means medical treatment, and/or surgical procedure
which is:

I. undertaken under General or Local Anesthesia in a hospital/day care
   centre in less than 24 hrs because of technological advancement, and
II. which would have otherwise required hospitalization of more than 24
   hours.

Def. 18. Dental Treatment means a treatment related to teeth or structures supporting
tooth including examinations, fillings (where appropriate), crowns, extractions
and surgery.

Def. 19. Dependents means only the family members listed below:

I. Your legally married spouse as long as she continues to be married to You;
II. Your children Aged between 91 days and 25 years if they are unmarried
III. Your natural parents or parents that have legally adopted You, provided
that the parent was below 65 years at his initial participation in the
Optima Restore Policy.
IV. Your Parent -in-law as long as Your spouse continues to be married to You
and were below 65 years at his initial participation in the Optima
Restore Policy.

All dependent parents must be financially dependent on You.

Def. 20. Dependent Child means a child (natural or legally adopted), who is unmarried,
Aged between 91 days and 25 years, financially dependent on the primary
Insured or Proposer and does not have his / her independent sources of
income.

Def. 21. Disclosure to information norm means 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.

Def. 22. 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. 23. 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. 24. Family Floater means a Policy described as such in the Schedule where under
You and Your Dependents named in the Schedule are insured under this Policy
as at the Commencement Date. The Sum Insured for a Family Floater means
the sum shown in the Schedule which represents Our maximum liability for any
and all claims made by You and/or all of Your Dependents during the Policy
Period.

Def. 25. Grace Period means the specified period of time immediately following the
premium due date during which a payment can be made to renew or continue a
Policy in force without loss of continuity benefits such as waiting periods and
Def. 39. 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 its scope and jurisdiction of license.

Def. 40. Migration means the right accorded to individual health insurance policyholders (including all members under family cover and members of group health insurance policy) to transfer the credits gained for pre-existing conditions and time-bound exclusions, with the same insurer.

Def. 41. Network Provider means Hospital enlisted by an insurer or a TPA or jointly by an insurer and a TPA to provide medical services to an insured by a cashless facility.

Def. 42. New Born Baby means baby born during the Policy Period and is aged upto 90 days.

Def. 43. Non Network Provider means any Hospital, day care centre or other provider that is not part of the Network.

Def. 44. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 45. OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 46. Portability means the right accorded to individual health insurance policyholders (including all members under family cover) to transfer the credits gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

Def. 47. Pre-existing Disease means any condition, ailment, injury or disease:
   a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
   b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

Def. 48. Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
   I. Such Medical Expenses are incurred for the same condition for which the Insured Person’s Hospitalization was required, and
   II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Def. 49. Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
   I. Such Medical Expenses are for the same condition for which the insured person’s hospitalization was required, and
   II. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Def. 50. Policy means your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure 1 and the Schedule (as the same may be amended from time to time).

Def. 51. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 52. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 53. Qualified Nurse is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 54. Reasonable & Customary Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 55. Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

Def. 56. 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. 57. Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 58. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 59. Unproven/Experimental treatment means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 60. We/Our/Us means the HDFC ERGO Health Insurance Limited

Def. 61. You/Your/Policyholder means the person named in the schedule who has concluded this policy with us.

D) Claim Related Information
For any claim related query, intimation of claim and submission of claim related documents, You can contact HDFC ERGO Health Insurance Limited through:
- Website: www.hdfcergohealth.com
- Toll Free: 1800-102-0333
- Fax: 1800-425-4077
- Courier: Claims Department, HDFC ERGO Health Insurance Limited Ground floor, Srinilaya – Cyber Spazio Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034
Or HDFC ERGO Health Insurance Limited iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III, Gurgaon-122016, Haryana
Additional Note: Please refer to the list of empanelled network centers on our website Or the list provided in the welcome kit.

E) Redressal of Grievance
If You have a grievance that You wish Us to redress, You may contact Us with the details of Your grievance through:
- Our website: www.hdfcergohealth.com
- E-mail: customerservice@hdfcergohealth.com
- E-mail specific for Senior citizens: seniorcitizen@hdfcergohealth.com
- Toll Free: 1800-102-0333
- Fax: +91-124-4584111
- Courier: Any of Our Branch office or Corporate office

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 The Grievance Cell, HDFC ERGO Health Insurance Limited, 2nd and 3rd Floor, iLABS Centre, Plot No 404-405, Udyog Vihar, Phase III, Gurgaon, Haryana-122016.

For updated details of grievance officer, kindly refer the link: https://www.hdfcergohealth.com/escalate-your-case.aspx

i. If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules

HDFC ERGO Health Insurance Limited

• is required for the medical management of the Illness or injury suffered by the Insured;
• must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
• must have been prescribed by a Medical Practitioner.
• must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 49. Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
I. Such Medical Expenses are 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. 50. Policy means your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Annexure 1 and the Schedule (as the same may be amended from time to time).

Def. 51. Policy Period means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 52. Policy Year means a year following the Commencement Date and its subsequent annual anniversary.

Def. 53. Qualified Nurse is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 54. Reasonable & Customary Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 55. Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

Def. 56. 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. 57. Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 58. TPA means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 59. Unproven/Experimental treatment means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 60. We/Our/Us means the HDFC ERGO Health Insurance Limited

Def. 61. You/Your/Policyholder means the person named in the schedule who has concluded this policy with us.
ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igma.irdai.gov.in/

The content details of the Insurance Ombudsman offices are as below

<table>
<thead>
<tr>
<th>OMBUDSMAN DETAILS</th>
<th>Jurisdiction of Office Union Territory, District</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHMEDABAD - Shri Kuldip Singh</td>
<td></td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: <a href="mailto:bimalokpal.ahmedabad@ecoi.co.in">bimalokpal.ahmedabad@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td>Gujarat, Dadra &amp; Nagar Haveli, Daman and Diu.</td>
<td></td>
</tr>
</tbody>
</table>

| BENGALURU - Smt. Neetia Shah |
| Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19-19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 – 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in |
| Karnataka, Madhya Pradesh, Chattisgarh |

| BHOPAL - Shri Guru Saran Shrivastava |
| Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Artel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in |
| Madhya Pradesh, Chattisgarh |

| BHUBANESHWAR - Shri Suresh Chandra Panda |
| Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 25966451/25966455 Fax: 0674 - 25966429 Email: bimalokpal.bhubaneswar@ecoi.co.in |
| Orissa |

| CHANDIGARH - Dr. Dinesh Kumar Verma |
| Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708247 Email: bimalokpal.chandigarh@ecoi.co.in |
| Punjab, Himachal Pradesh, Jammu & Kashmir, Chandigarh. |

| CHENNAI - Shri M. Vasanthan Krishna |
| Office of the Insurance Ombudsman, Fatima Ahltaar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333686 / 24335284 Fax: 044 - 24333684 Email: bimalokpal.chennai@ecoi.co.in |
| Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry). |

| DELHI - Shri Sudhir Krishna |
| Office of the Insurance Ombudsman, 2/2, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23322481/23321504 Email: bimalokpal.delhi@ecoi.co.in |
| Delhi |

| GUWAHATI - Shri Kiriki B. Sahi |
| Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASAM). Tel.: 0361 - 2632204 / 2602005 Email: bimalokpal.guwahati@ecoi.co.in |
| Assam, Meghalaya, Manipur, Mizoram, Nagaland and Tripura. |

| HYDERABAD - Shri I. Suresh Babu |
| Office of the Insurance Ombudsman, 6-2-46, 1st floor, ‘Main Court’, Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool,Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in |
| Andhra Pradesh, Telangana, Yarnam and part of Territory of Pondicherry. |

| JAIPUR - Smt. Sandhya Baliga |
| Office of the Insurance Ombudsman, Jeevan Nidi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in |
| Rajasthan, Kerala, Lakshadweep, Mahe-a part of Pondicherry. |

| ERNAKULAM - Ms. Poonam Bodha |
| Office of the Insurance Ombudsman, 2nd Floor, Pullinat Bldg., Opp. Coochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359336 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in |
| Kerala, West Bengal, Sikkim, Andaman & Nicobar Islands. |

| KOLKATA - Shri P. K. Rath |
| Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA – 700 072. Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in |

| LUCKNOW - Shri Justice Anil Kumar Srivastava |
| Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in |

| NOIDA - Shri Chandra Shekhar Prasad |
| Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt. Gautam Buddh Nagar, U.P. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in |

| PATNA - Shri N. K. Singh |
| Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building., Bazan Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patra@ecoi.co.in |
| Bihar, Jharkhand. |

| 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.: 020-4131255 Email: bimalokpal.pune@ecoi.co.in |
| Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region. |

This Policy is subject to regulation 12 of IRDAI (Protection of Policyholder’s Interests) Regulations 2017
Annexure I – List of Non-Medical Expenses

<table>
<thead>
<tr>
<th>Sl No</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BABY FOOD</td>
</tr>
<tr>
<td>2</td>
<td>BABY UTILITIES CHARGES</td>
</tr>
<tr>
<td>3</td>
<td>BEAUTY SERVICES</td>
</tr>
<tr>
<td>4</td>
<td>BELTS/ BRACES</td>
</tr>
<tr>
<td>5</td>
<td>BUDS</td>
</tr>
<tr>
<td>6</td>
<td>COLD PACK/HOT PACK</td>
</tr>
<tr>
<td>7</td>
<td>CARRY BAGS</td>
</tr>
<tr>
<td>8</td>
<td>EMAIL / INTERNET CHARGES</td>
</tr>
<tr>
<td>9</td>
<td>FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)</td>
</tr>
<tr>
<td>10</td>
<td>LEGGINGS</td>
</tr>
<tr>
<td>11</td>
<td>LAUNDRY CHARGES</td>
</tr>
<tr>
<td>12</td>
<td>MINERAL WATER</td>
</tr>
<tr>
<td>13</td>
<td>SANITARY PAD</td>
</tr>
<tr>
<td>14</td>
<td>TELEPHONE CHARGES</td>
</tr>
<tr>
<td>15</td>
<td>GUEST SERVICES</td>
</tr>
<tr>
<td>16</td>
<td>CREPE BANDAGE</td>
</tr>
<tr>
<td>17</td>
<td>DIAPER OF ANY TYPE</td>
</tr>
<tr>
<td>18</td>
<td>EYELET COLLAR</td>
</tr>
<tr>
<td>19</td>
<td>SLINGS</td>
</tr>
<tr>
<td>20</td>
<td>BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES</td>
</tr>
<tr>
<td>21</td>
<td>SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED</td>
</tr>
<tr>
<td>22</td>
<td>TELEVISION CHARGES</td>
</tr>
<tr>
<td>23</td>
<td>SURCHARGES</td>
</tr>
<tr>
<td>24</td>
<td>ATTENDANT CHARGES</td>
</tr>
<tr>
<td>25</td>
<td>EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)</td>
</tr>
<tr>
<td>26</td>
<td>BIRTH CERTIFICATE</td>
</tr>
<tr>
<td>27</td>
<td>CERTIFICATE CHARGES</td>
</tr>
<tr>
<td>28</td>
<td>COURIER CHARGES</td>
</tr>
<tr>
<td>29</td>
<td>CONVEYANCE CHARGES</td>
</tr>
<tr>
<td>30</td>
<td>MEDICAL CERTIFICATE</td>
</tr>
<tr>
<td>31</td>
<td>MEDICAL RECORDS</td>
</tr>
<tr>
<td>32</td>
<td>PHOTOCOPIES CHARGES</td>
</tr>
<tr>
<td>33</td>
<td>MORTUARY CHARGES</td>
</tr>
<tr>
<td>34</td>
<td>WALKING AIDS CHARGES</td>
</tr>
<tr>
<td>35</td>
<td>OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)</td>
</tr>
<tr>
<td>36</td>
<td>SPACER</td>
</tr>
<tr>
<td>37</td>
<td>SPIROMETRE</td>
</tr>
<tr>
<td>38</td>
<td>NEBULIZER KIT</td>
</tr>
<tr>
<td>39</td>
<td>STEAM INHALER</td>
</tr>
<tr>
<td>40</td>
<td>ARMSLING</td>
</tr>
<tr>
<td>41</td>
<td>THERMOMETER</td>
</tr>
<tr>
<td>42</td>
<td>CERVICAL COLLAR</td>
</tr>
<tr>
<td>43</td>
<td>SPLINT</td>
</tr>
<tr>
<td>44</td>
<td>DIABETIC FOOT WEAR</td>
</tr>
<tr>
<td>45</td>
<td>KNEE BRACES (LONG/ SHORT/ HINGED)</td>
</tr>
<tr>
<td>46</td>
<td>KNEE IMMOBILIZER/SHOULDER IMMOBILIZER</td>
</tr>
<tr>
<td>47</td>
<td>LUMBO SACRAL BELT</td>
</tr>
<tr>
<td>48</td>
<td>NIMBUS BED OR WATER OR AIR BED CHARGES</td>
</tr>
<tr>
<td>49</td>
<td>AMBULANCE COLLAR</td>
</tr>
<tr>
<td>50</td>
<td>AMBULANCE EQUIPMENT</td>
</tr>
<tr>
<td>51</td>
<td>ABDOMINAL BINDER</td>
</tr>
<tr>
<td>52</td>
<td>PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES</td>
</tr>
<tr>
<td>53</td>
<td>SUGAR FREE TABLETS</td>
</tr>
<tr>
<td>54</td>
<td>CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)</td>
</tr>
<tr>
<td>55</td>
<td>ECG ELECTRODES</td>
</tr>
<tr>
<td>56</td>
<td>GLOVES</td>
</tr>
<tr>
<td>57</td>
<td>NEBULISATION KIT</td>
</tr>
<tr>
<td>58</td>
<td>ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]</td>
</tr>
<tr>
<td>59</td>
<td>KIDNEY TRAY</td>
</tr>
<tr>
<td>60</td>
<td>MASK</td>
</tr>
<tr>
<td>61</td>
<td>OUNCE GLASS</td>
</tr>
<tr>
<td>62</td>
<td>OXYGEN MASK</td>
</tr>
<tr>
<td>63</td>
<td>PELVIC TRACTION BELT</td>
</tr>
<tr>
<td>64</td>
<td>PAN CAN</td>
</tr>
<tr>
<td>65</td>
<td>TROLLY COVER</td>
</tr>
<tr>
<td>66</td>
<td>UROMETER, URINE JUG</td>
</tr>
<tr>
<td>67</td>
<td>AMBULANCE</td>
</tr>
<tr>
<td>68</td>
<td>VASOFIX SAFETY</td>
</tr>
</tbody>
</table>
## Schedule of benefits

**Optima RESTORE Individual**

<table>
<thead>
<tr>
<th>Basic Sum Insured per Policy Year (Rs. in Lakh)</th>
<th>3.00</th>
<th>5.00</th>
<th>10.00</th>
<th>15.00</th>
<th>20.00, 25.00, 50.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a) In-patient Treatment</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
</tr>
<tr>
<td>1b) Pre-Hospitalization</td>
<td>Covered, upto 60 Days</td>
<td>Covered, upto 60 Days</td>
<td>Covered, upto 60 Days</td>
<td>Covered, upto 60 Days</td>
<td>Covered, upto 60 Days</td>
</tr>
<tr>
<td>1c) Post-Hospitalization</td>
<td>Covered, upto 180 Days</td>
<td>Covered, upto 180 Days</td>
<td>Covered, upto 180 Days</td>
<td>Covered, upto 180 Days</td>
<td>Covered, upto 180 Days</td>
</tr>
<tr>
<td>1d) Day Care Procedures</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
</tr>
<tr>
<td>1e) Domiciliary Treatment</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
</tr>
<tr>
<td>1f) Organ Donor</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
<td>Covered upto sum insured</td>
</tr>
<tr>
<td>1g) Emergency Ambulance</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
</tr>
<tr>
<td>1h) Daily Cash for choosing Shared Accommodation</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 1,000 per day, Maximum Rs. 6,000</td>
</tr>
<tr>
<td>1i) E-Opinion in respect of a Critical Illness</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>1j) Emergency Air Ambulance Cover</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered upto Rs. 2,5 Lacs per hospitalization and maximum upto sum insured in an year</td>
<td>Covered upto Rs. 2,5 Lacs per hospitalization and maximum upto sum insured in an year</td>
<td>Covered upto Rs. 2,5 Lacs per hospitalization and maximum upto sum insured in an year</td>
</tr>
<tr>
<td>2) Restore Benefit</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
</tr>
<tr>
<td>3) Health Checkup (per person)</td>
<td>Not Applicable</td>
<td>Upto Rs. 1500</td>
<td>Upto Rs. 2000</td>
<td>Upto Rs. 4000</td>
<td>Upto Rs. 5000</td>
</tr>
<tr>
<td>4) Multiplier Benefit</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
</tr>
</tbody>
</table>
# Optima Restore, Policy Wording
**HDFC ERGO Health Insurance Limited**

## Optima RESTORE Family

<table>
<thead>
<tr>
<th>Basic Sum Insured per Policy per Policy Year (Rs. in Lakh)</th>
<th>3.00</th>
<th>5.00</th>
<th>10.00</th>
<th>15.00</th>
<th>20.00, 25.00, 50.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a) In-patient Treatment</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
</tr>
<tr>
<td>1b) Pre-Hospitalization</td>
<td>Covered, up to 60 Days</td>
<td>Covered, up to 60 Days</td>
<td>Covered, up to 60 Days</td>
<td>Covered, up to 60 Days</td>
<td>Covered, up to 60 Days</td>
</tr>
<tr>
<td>1c) Post-Hospitalization</td>
<td>Covered, up to 180 Days</td>
<td>Covered, up to 180 Days</td>
<td>Covered, up to 180 Days</td>
<td>Covered, up to 180 Days</td>
<td>Covered, up to 180 Days</td>
</tr>
<tr>
<td>1d) Day Care Procedures</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
</tr>
<tr>
<td>1e) Domiciliary Treatment</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
</tr>
<tr>
<td>1f) Organ Donor</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
<td>Covered up to sum insured</td>
</tr>
<tr>
<td>1g) Emergency Ambulance</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
<td>Upto Rs. 2,000 per Hospitalization</td>
</tr>
<tr>
<td>1h) Daily Cash for choosing Shared Accommodation</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 800 per day, Maximum Rs. 4,800</td>
<td>Rs. 1,000 per day, Maximum Rs. 6,000</td>
</tr>
<tr>
<td>1i) E-Opinion in respect of a Critical Illness</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>1j) Emergency Air Ambulance Cover</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered up to Rs. 2.5 Lacs per hospitalization and maximum up to sum insured in an year</td>
<td>Covered up to Rs. 2.5 Lacs per hospitalization and maximum up to sum insured in an year</td>
<td>Covered up to Rs. 2.5 Lacs per hospitalization and maximum up to sum insured in an year</td>
</tr>
<tr>
<td>2) Restore Benefit</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
<td>Equal to 100% of Basic Sum Insured</td>
</tr>
<tr>
<td>3) Health Checkup (per policy)</td>
<td>Not Applicable</td>
<td>Upto Rs. 2500</td>
<td>Upto Rs. 5000</td>
<td>Upto Rs. 8000</td>
<td>Upto Rs. 10,000</td>
</tr>
<tr>
<td>4) Multiplier Benefit</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum up to 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum up to 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum up to 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum up to 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
<td>Bonus of 50% of the Basic Sum Insured for every claim free year, maximum up to 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal</td>
</tr>
</tbody>
</table>

---

We would be happy to assist you. For any help contact us at: E-mail: customerservice@hdfcergohealth.com | Toll Free: 1800 102 0333

HDFC ERGO Health Insurance Limited (Formerly known as Apollo Munich Health Insurance Company Limited.) • Central Processing Centre: 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyaq Vihar, Phase-III, Gurugram-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurugram-122001, Haryana • Registered Off. 101, First Floor, Inizio, Cardinal Gracious Road, Chakala, Opposite P & G Plaza, Andheri (East), Mumbai, Maharashtra 400069 India • Tel: +91-124-4584333 • Fax: +91-124-4584111 • Website: www.hdfcergohealth.com

For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. • Tax laws are subject to change. • IRDAI Registration Number - 131 • CIN: U66030MH2006PLC331263 • Optima Restore UIN: HDHLP21322V062021