Optima Plus - Prospectus

Eligibility

- This policy covers persons in the age group 91 days to 65 years.
- The maximum entry age is restricted upto 65 years.
- Child between 91 days to 5 years can be insured only when either parent is getting insured under this policy.
- The policy offers coverage on individual sum insured basis.
- This policy can be issued to an individual and/or family.
- The family includes self, spouse, dependent children and dependent parents.

Policy Period

- The policy will be issued for 1 year /2 years period

Benefits

The policy pays for the benefits mentioned below, in excess of the deductible opted by you.

- In-patient Treatment – Covers medical expenses for hospitalisation due to an illness or accident. We will pay for the medical expenses for room rent, boarding expenses, nursing, intensive care unit, medical practitioner(s), anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs and consumables, diagnostic procedures, cost of prosthetic & other devices or equipments if implanted internally during a surgical procedure.

Note pertaining specifically to AYUSH Treatments only:

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

- Pre-Hospitalisation - The medical expenses incurred due to an Illness in 60 days immediately before the insured person was hospitalised.
- Post-Hospitalisation - The medical expenses incurred in 90 days immediately after the insured person was discharged post Hospitalisation.
- Day care procedures – The medical expenses for 140day care procedures which do not require 24 hours hospitalisation due to technological advancement in medical science.
- Organ Donor - The medical expenses on harvesting the organ from the donor.
- Emergency Ambulance – Expenses upto Rs. 2000 per hospitalisation for utilizing ambulance service for transporting insured person to hospital.
- Domiciliary Treatment - The Medical Expenses incurred by an Insured Person for availing medical treatment at his home which would otherwise have required Hospitalisation

Waiver of Deductible

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

a) Insured Person has enrolled with Us for first time under this Policy before the age of 50 years and has renewed with Us continuously and without interruption,
b) This option can be exercised by the Insured Person in the age group 58 - 60 years at the time of renewal only,
c) Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered in this Policy.

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

Key Definitions

Pre-existing Condition means any condition, ailment, injury, or disease:

i) That is/are diagnosed by a physician within 36months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii) For which **Medical advice** or treatment was recommended by, or received from, a physician within 36months prior to the effective date of the policy or its reinstatement.

Any One Illness means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/nursing home where treatment may have been taken. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this Policy.

Deductible means a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount (as mention in Policy Schedule) of the covered expenses, which will apply before any benefits are payable by the insurer. A Deductible does not reduce the Sum Insured.

Exclusions

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

b. Waiting Periods

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

c. 30-day Waiting Period: Code – Excl03

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

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

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

d. Specified disease/procedure waiting period: Code – Excl02

I. Expenses related to the treatment of the listed Conditions, surgeries/treatments as mentioned in the table below shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident**.

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

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

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

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

VI. List of specific diseases/procedure:

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

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

e. P re- Existing Diseases: Code- Excl01

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

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

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

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

f. Permanent Exclusions

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

i. **Investigation & Evaluation: Code – Excl04**

a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.

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

ii. **Rest Cure, rehabilitation and respite care: Code – Excl05** – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

xv. **Maternity: Code – Excl18**

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

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

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

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

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

xx. Congenital external diseases, defects or anomalies,

xxi. Stem cell harvesting

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

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

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

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

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

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

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

xxix. Treatment taken on Outpatient basis

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

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

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

xxxiii. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs crutches and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses attached and also available on www.hdfcergo.com.

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

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

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

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

Requirement

- Completed proposal form

Pre- Policy Checkup

- Pre-Policy Checkup at our network may be required based upon the age and sum insured as mentioned below.

Sum Insured (Rs.)	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**
Deductible (Rs.)	**100,000**	**200,000**	**300,000**	**400,000**	**500,000**
18-45 Yrs	Nil	Nil	Nil	Nil	Nil
46-55 Yrs	Cat 3	Cat 3	Cat 1	Cat 1	Cat 1
56-60 Yrs	Cat 4	Cat 4	Cat 2	Cat 2	Cat 2
61-65 Yrs	Cat 6	Cat 6	Cat 5	Cat 5	Cat 5

Category	Tests
Cat 1	ME, FBS, ECG
Cat 2	ME, RUA, FBS, ECG
Cat 3	ME, RUA, FBS, ECG, CBC, TC
Cat 4	ME, RUA, FBS, CBC, Lipids, ECG
Cat 5	ME, RUA, FBS, CBC, Lipids, TMT, SGOT, Total Proteins, Sr Creat, PSA (males), USG Abd (females)
Cat 6	ME, RUA, FBS, CBC, Lipids, TMT, LFT, Sr Creat, PSA (males), USG Abd (females)
ME-Medical Examination (Report), CBC-Complete Blood Count, ECG-Electro Cardio Gram, FBS-Fasting Blood Sugar, Lipids-Lipid Profile, Sr Creatinine-Serum Creatinine, PSA-Prostate Specific antigen, RUA-Routine Urine Examination, TMT-Treadmill Test, USG-Ultrasonogram, SGOT-Serum Glutamic Oxaloacetic Transaminase, TC-Total Cholesterol, LFT-Liver Function Test	

We will reimburse 50% of the expenses incurred per insured person on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

Premium Rates

Annual Premium (All figures in INR)					
Sum Insured	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**
Deductible	**100,000**	**200,000**	**300,000**	**400,000**	**500,000**
91 Days-35 Years	1,999	1,049	899	799	699
36-45 Years	2,750	1,500	1,400	1,300	1,200
46-60 Years	4,813	2,925	2,170	2,015	1,860
61-75 Years	10,106	5,704	3,472	2,519	2,325
>75 Years	24,053	14,254	9,090	6,894	6,640

- The premium mentioned is Annual Premium.
- All premium rates are exclusive of service tax and applicable cess.
- Premium rates can be revised subject to approval from IRDA
- 7.5% Discount on premium if Insured Person is paying premium of 2 years in advance.

For example:

(1) Proposed Insured Age 33 years opting for 2 year policy with Sum Insured of Rs 5 Lac and deductible Rs 2 Lac.
Calculation – 1,049 X 2 X 92.5% = Rs. 1940.65/- plus taxes.

(2) Proposed Insured Age 35 years opting for 2 year policy with Sum Insured of Rs 5 Lac and deductible Rs 2 Lac.
Calculation – (1,049+1,500) X 92.5% = Rs. 2357.82/- plus taxes.

Discounts

1) Family Discount of 10% if 2 or more family members are covered under same policy.
2) Discount of 10% on published tariff, if customer buys Optima Plus through Our Online/Tele Sales channel.

Loadings

- 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 through a counter offer letter. You need to revert to us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. in case, you neither accept the counter offer nor revert to us within 15 days, we shall cancel your application and refund the premium paid within next 7 days.
- Please note that we will issue policy only after getting your consent.

e. 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.

f. Fraud

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

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

g. Free Look Period

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

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

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

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;

h. Multiple Policies

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

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

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

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

i. Alterations to the Policy

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

j. Renewal of Policy

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

1. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.
2. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
3. No loading shall apply on renewals based on individual claims experience
4. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.
5. Renewal premium due can be paid prior to the due date as per norms set out by the Company

k. 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.

l. 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.

m. Change of Policyholder

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

n. 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.

o. Notices

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

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

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

p. 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.

q. Cancellation

i. The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.
Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

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

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

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

r. Waiver of Deductible

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

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

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

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

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

s. Non Disclosure or Misrepresentation:

I. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found

to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

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

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

(1) Permanently exclude the disease/condition and continue with the Policy
(2) Incorporate additional waiting period of not exceeding 3 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
(3) 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.

t. Moratorium Period

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

u. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

v. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

w. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

x. 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**.

Claim Procedure
All claims under this policy will be processed and settled by specified Third Party Administrator (TPA) licensed by IRDA.

Intimation & Assistance – Incase of any hospitalisation or an event which might give rise to a claim, we request you to contact your designated TPA. Details of your designated TPA will available on our website and will be provided in your Optima Plus policy kit.

Procedure to avail Cashless facility -

- For any emergency Hospitalisation, your designated TPA must be informed no later than 24 hours after hospitalization.
- For any planned hospitalization, kindly seek cashless authorization from your designated TPA atleast 48 hours prior to the hospitalization.
- TPA 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 1 hour of receipt of documents.
- Please pay the non-medical and expenses not covered to the hospital prior to the discharge.
- In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 1 hour.
- The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the bank rate.

While availing Cashless facility

- Insured person is entitled for cashless facility only in Our empanelled hospitals.
- Please refer to the list of empanelled hospitals on our website www.hdfcergo.com or the list provided along with Policy kit or call us on our Contact number at 022 6242 6226.
- Rejection of cashless facility in no way indicates rejection of the claim.

Procedure for Reimbursement of Medical Expenses –

- Our TPA must be informed no later than 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/documents mentioned therein to your designated TPA within 15 days of the occurrence of the Incident.
- Please refer to claim form for complete documentation.

- If there is any deficiency in the documents/information submitted by you, the TPA will send the deficiency letter within 7 days of receipt of the claim documents.
- The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the bank rate.
- The cheque will be sent in the name of the proposer.

Important Points for Claims Procedure:

- Payment will only be made for items covered under your policy in excess of the deductible and upto the limits therein.
- In the case of a covered hospitalisation, the costs of which were not initially estimated to exceed the deductible but were subsequently found likely to exceed the deductible, the intimation should be submitted along with a copy of intimation made to the other insurer /reimbursement provider immediately on knowing that the deductible is likely to be exceeded.

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

Tax Benefit The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

Grievance Redressal Procedure

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

- Website: www.hdfcergo.com
- Contact No 022 6234 6234 / 0120 6234 6234
- Contact Details for Senior Citizen: 022 – 6242 – 6226 | seniorcitizen@hdfcergo.com
- E-mail: grievance@hdfcergo.com

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

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

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

Contact Points	First Contact Point	Escalation level 1	Escalation level 2

Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

i. If Insured person is not satisfied with the redressal of grievance through above methods**,** the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Disclaimer

This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification.

S.No	List of Non Medical Expenses
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS

6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSp|TAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HTNGED)

46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY