Optima RESTORE
Customer Information Sheet

HDFC ERGO HEALTH

Description is illustrative and not exhaustive

TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
Product Name	Optima Restore	
What am I covered for:	**a. In-patient Treatment -** Covers hospitalisation expenses for period more than 24 hrs. **b. Pre-Hospitalisation -** Medical expenses incurred in 60 days before the hospitalisation. **c. Post-Hospitalisation -** Medical expenses incurred in 180 days after the hospitalisation. **d. Day-Care procedures -** Medical expenses for day care procedures. **e. Domiciliary Treatment -** Medical expenses incurred for availing medical treatment at home which would otherwise have required hospitalisation. **f. Organ Donor-** Medical expenses on harvesting the organ from the donor for organ transplantation. **g. Ambulance Cover -** Upto Rs. 2,000 per hospitalisation for utilizing ambulance service for transporting insured person to hospital in case of an emergency. **h. Daily Cash for choosing shared accommodation -** Daily cash amount if hospitalised in shared accommodation in network hospital and hospitalisation exceeds 48 hrs. **i. E-Opinion in respect of a Critical Illness -** Second opinion by a Medical Practitioner from Our panel, for a Critical Illness suffered during the policy period. **j. Emergency Air Ambulance Cover-** Covers, Expenses for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions. **k. Restore Benefit -** 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.	Section I.1 a) Section I.1 b) Section I.1 c) Section I.1 d) Section I.1 e) Section I.1 f) Section I.1 g) Section I.1 h) Section I.1 i) Section I.1.j) Section II.
What are the major exclusions in the policy:	Following is a partial list of the policy exclusions. Please refer to the policy wording for the complete list of exclusions. 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 or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, treatment of obesity and any weight control program, Psychiatric, genetic disorders, congenital external diseases, defects or anomalies, sleep apnoea, expenses arising from HIV or AIDs and related diseases, sterility, treatment to effect or to treat infertility, any fertility, sub-fertility, surrogate or vicarious pregnancy, birth control, circumcisions, treatment for correction of refractive error, plastic surgery or cosmetic surgery unless required due to an Accident, Cancer or Burns, any non-allopathic treatment.	Section V. c)
Waiting Period	• 30 days for all illnesses (except accident) in the first year and is not applicable in subsequent renewals • 24 months for specific illness and treatments in the first two years and is not applicable in subsequent renewals • Pre-existing Diseases will be covered after a waiting period of 36 months	Section V.A i) Section V.A ii) Section V.A iii)
Payout basis	Payout on indemnity payment basis.	Section I
Cost Sharing	Not Applicable	
Renewal Conditions	• 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. • 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.	Section VI.n)

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Renewal Benefits	**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. **Preventive Health Check-up -** We will reimburse upto the stated amount towards cost incurred in the preventive health check-up. **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.	Section IV Section III
Cancellation	This policy would be cancelled on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by any Insured Person, upon giving 30 days notice.	Section VI.r)
How to Claim	Please contact Us atleast 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 VIII

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 (Formerly known as Apollo Munich Health Insurance Company Limited.) • Central Processing Centre: 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog 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 • Email: customerservice@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 • UIN: APOHLIP18125V041718

Optima RESTORE
Policy Wording

HDFC ERGO HEALTH

HDFC ERGO Health Insurance Ltd. 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.

We will cover the Medical Expenses for:		In addition to the waiting periods (Section V a) and general exclusions (Section V c), We will also not cover expenses
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 & consumables; • Diagnostic procedures.	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.
	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).	1. Claims which have NOT been admitted under 1 a) and 1d) 2. Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
	c. Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 180 days after discharge from the Hospital.	1. Claims which have NOT been admitted under 1 a) and 1d) 2. Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
	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. Indicative list of Day Care Procedures • Cancer Chemotherapy • Liver biopsy • Coronary angiography • Haemodialysis • Operation of cataract • Nasal sinus aspiration	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.
	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: 1. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, 2. The patient takes treatment at home on account of non availability of room in a Hospital. Pre Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation	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). 2. Post-Hospitalisation expenses.

Important terms you should know

Sum Insured means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period, 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.

In-patient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

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.

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.

Shared accommodation means a Hospital room with two or more patient beds

Single occupancy or any higher accommodation and type means a Hospital room with only one patient bed.

	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.	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.
	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.	1. Claims which have NOT been admitted under Section 1a) and Section 1d). 2. Healthcare or ambulance service provider not registered with road traffic authority.
	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.	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).
	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 of Specified Severity, Open Chest CABG, Myocardial Infarction (First Heart Attack of specific severity), Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs and Stroke resulting in permanent symptoms.	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(1) 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; upto 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 II. 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.	

Section III. 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 upto 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 the waiting 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.

Plan	3 Lacs	5 Lacs	10 Lacs	15 Lacs	20,25,50 Lacs
Optima Restore Individual	NA	Upto a maximum of Rs.1,500 per insured person, only once at the end of a block of every continuous 2 Policy Years.	Upto a maximum of Rs.2,000 per insured person at the end of each year at renewal.	Upto a maximum of Rs.4,000 per insured person, at the end of each year at renewal	Upto Maximum of Rs. 5,000 per Insured Person, at the end of each year at renewal
Optima Restore Family	NA	Upto a maximum of Rs.2,500 per policy, only once at the end of a block of every continuous 2 Policy Years.	Upto a maximum of Rs.5,000 per policy at the end of each year at renewal	Upto a maximum of Rs.8,000 per policy, at the end of each year at renewal.	Upto Maximum of Rs. 10,000 per policy, at the end of each year at renewal.

Section IV. 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 benefit will be offered to the extent of sum of previous sum insured and accrued multiplier bonus, portability 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 V. Special terms and conditions

A. Waiting Period

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

i) We are not liable for any claim arising due to condition for which appearance of signs/symptoms, consultation, investigation, treatment or admission started within 30 days from Policy Commencement Date, except for the claims arising due to an Accident.

ii) A waiting period of 24 months from the first policy commencement date will be applicable to the medical and surgical treatment of illnesses / diagnoses or surgical procedures mentioned in the following table. However this waiting period will not be applicable where the underlying cause is cancer(s).

Sl No	Organ / Organ System	Illness / diagnoses (irrespective of treatments medical or surgical)	Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)
a	Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for Nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
b	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
c	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
d	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
e	Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f	Eye	• Cataract • Retinal detachment • Glaucoma	Nil
g	Others	Nil	• Surgery of varicose veins and varicose ulcers
h	General (Applicable to all organ systems/ organs whether or not described above)	• Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc	• NIL

iii) 36 months waiting period from policy Commencement Date for all Pre-existing Conditions declared and/or accepted at the time of application.

PI Note: Coverage under the policy for any past illness/condition or surgery is subject to the same being declared at the time of application and accepted by Us without any exclusion.

B. Reduction in waiting periods

1) If the proposed Insured Person is presently covered and has been continuously covered without any lapses under:

a) any health insurance plan with an Indian non life insurer as per guidelines

on portability , Or

b) any other similar health insurance plan from Us,

Then

(a) The waiting periods specified in Section 6 a i), ii) and iii) of the Policy stands waived; And :

(b) The waiting periods specified in the Section 6 a i), ii) and iii) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy; And

(c) If the proposed Sum Insured for a proposed Insured Person is more than the Sum Insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the Sum Insured any other accrued Sum Insured under the previous health insurance policy.

2) The reduction in the waiting period specified above shall be applied subject to the following:

a) We will only apply the reduction of the waiting period if We have received the database and past claim history related information as mandated under portability guidelines issued by insurance regulator from the previous Indian insurance company (if applicable);

b) We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation and information.

c) We will retain the right to underwrite the proposal.

d) We shall consider only completed years of coverage for waiver of waiting periods. Policy extensions if any sought during or for the purpose of porting insurance policy shall not be considered for waiting period waiver.

C. General exclusions

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

Non Medical Exclusions

i) War or similar situations: Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (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.

ii) Any Insured Person committing or attempting to commit a breach of law with criminal intent.

iii) Intentional self injury or attempted suicide while sane or insane.

iv) Dangerous acts (including sports):

An Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in a professional or semi professional nature.

Medical Exclusions

v) Treatment of illness or injury as a consequence of the use of alcohol, tobacco, narcotic or psychotropic substances.

vi) Prosthetic and other devices which are self detachable /removable without surgery involving anaesthesia

vii) Treatment availed outside India

viii) Treatment at a healthcare facility which is NOT a Hospital.

ix) Treatment of obesity and any weight control program.

x) Treatment for correction of eye sight due to refractive error

xi) Cosmetic, aesthetic and re-shaping treatments and surgeries:

a. Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.

b. Circumcisions (unless necessitated by Illness or injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.

xii) Types of treatment, defined Illnesses/ conditions/ supplies:

a. Non allopathic treatment.

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

c. Charges related to peritoneal dialysis, including supplies

d. Admission primarily for administration of monoclonal antibodies or IV immunoglobulin infusion.

e. Experimental, investigational or unproven treatment devices and pharmacological regimens.

f. Admission primarily for diagnostic and evaluation purposes only

g. Any diagnostic expenses which is not related and not incidental to any illness which is not covered in this Policy

h. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition").

i. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment);

j. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements

k. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

l. Parkinson and Alzheimer's disease,

m. Sleep-apnoea.

n. External congenital diseases, defects or anomalies,genetic disorder.

o. Stem cell therapy or surgery, or growth hormone therapy.

p. Venereal disease, sexually transmitted disease or illness;

q. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.

r. Any expense attributable directly or indirectly to pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or child birth (including caesarean section), except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only.

s. Treatment for sterility, infertility (primary or secondary), assisted conception or other related conditions and complications arising out of the same.

t. Birth control, and similar procedures including complications arising out of the same.

u. The expense incurred by the insured on organ donation.

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

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

xiii) Any non medical expenses mentioned in Annexure I.

xiv) Healthcare providers (Hospitals /Medical Practitioners)

a. Any Medical Expenses incurred using facility of any Medical Practitioners or institution that We have told You (in writing) is not to be used at the time of renewal or at any specific time during the policy period.

b. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

c. 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.

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

xvi) Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured.

xvii) Admission for administration of Intra-articular or Intra-lesional injections, Monoclonal antibodies like Rituximab/Infliximab/Tratsuzumab, etc (Trade name Remicade, Rituxan, Herceptin, etc), Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc) or IV immunoglobulin infusion

Section VI. General Conditions

a. Conditions to be followed

The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability. The premium for the policy will remain the same for the policy period as mentioned in policy schedule. The policy will be issued for a period for 1 or 2 year(s) period based on Policy Period selected and mentioned on the Policy Schedule, the sum insured & benefits will be applicable on Policy Year basis.

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, Bhayandar, 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 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 under a single Optima Restore Policy. An 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 6 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.

The discount grid would be as per the table below:

1 Year Policy

Time Interval (calculated from policy risk start date)					
Average Step Target	Risk start date or date of download of mobile application -90 days	91-180 days	181-270 days	271-300 days	Maximum Discount at the end of the year
5000 or below			0%	0%	0%
5001 to 8000	0.5%	0.5%	0.5%	0.5%	2%
8001 to 10000	1.25%	1.25%	1.25%	1.25%	5%
Above 10000	2%	2%	2%	2%	8%

2 Year Policy

Time Interval (calculated from policy risk start date)									
Average Step target	Risk start date or date of download of mobile application - 90 days	91-180 days	181-270 days	271-360 days	361-450 days	451-540 days	541-630 days	631-660 days	Max Discount at the end of 2 years
5000 or below	0%	0%	0%	0%	0%	0%	0%	0%	0%
5001 to 8000	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	2%
8001 to 10000	0.625%	0.625%	0.625%	0.625%	0.625%	0.625%	0.625%	0.625%	5%
Above 10000	1%	1%	1%	1%	1%	1%	1%	1%	8%

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

Policy start date	1st Jan 2016
Policy Tenure	1 year
Time Interval	

	Risk start date or date of download of mobile application -90 days	91 days-180 days	181 days-270 days	271- 300 days
Average steps taken in the defined time period	8500	10000	5001	7500
Discount %applicable	1.25%	1.25%	0.5%	0.5%

Total discount applicable on renewal premium = 3.5%

e. Notification of Claim

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

f. Cashless Service:

	Treatment, Consultation or Procedure	Treatment, Consultation or Procedure Taken at	Cashless Service is Available	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars
i)	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation
ii)	If any treatment, consultation or procedure for which a claim may be made to be taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

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 request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. 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 all 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.
vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
viii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
ix) Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
x) Copy of settlement letter from other insurance company or TPA
xi) Stickers and invoice of implants used during surgery
xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xiv) Legal heir certificate

h. The Insured Person shall have to undergo medical examination by Our authorised Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

i. Claims Payment

i) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
ii) We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule), payments under this Policy shall only be made in Indian Rupees within India.
iii) The assignment of benefits of the policy shall be subject to applicable law.
iv) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
v) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after Hospitalisation in the case of an emergency.
vi) We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of receipt of last necessary document(s) / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the

applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document(s) to the date of payment of claim. For the purpose of this clause, 'bank rate' shall mean the bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

vii) Where the circumstances of a claim warrant an investigation in our Opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days , We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim

viii) Healthcare Advisory Benefit: We may suggest alternate Network Provider in specific cases of surgical or medical treatment, should the Insured member accept and utilize one of the alternatives suggested he would be eligible for a lump sum benefit of Rs 5000.

Please note: The acceptance of our recommendation is not obligatory on the Insured member and We are not liable for any outcome of the treatment conducted at the network centre

j. Non Disclosure or Misrepresentation:

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 30 day notice by sending an endorsement to Your address shown in the Schedule and
- the claim under such Policy if any, shall be rejected/repudiated forthwith.

k. Dishonest or Fraudulent Claims:

If any claim is in any manner fraudulent, or is supported by any fraudulent means or devices, whether by You or the Insured Person or anyone acting on behalf of You or an Insured Person, then this 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 30 day notice by sending an endorsement to Your address shown in the Schedule; and
- all benefits payable, if any, under such Policy shall be forfeited with respect to such claim.

l. Other Insurance

If at the time when any claim is made under this Policy, insured has two or more policies from one or more Insurers to indemnify treatment cost, which also covers any claim (in part or in whole) being made under this Policy, then the Policy holder shall have the right to require a settlement of his claim in terms of any of his policies. The insurer so chosen by the Policy holder shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen Policy.

Provided further that, If the amount to be claimed under the Policy chosen by the Policy holder, exceeds the sum insured under a single Policy after considering the deductibles or co-pay (if applicable), the Policy holder shall have the right to choose the insurers by whom claim is to be settled. In such cases, the respective insurers may then settle the claim by applying the Contribution clause. This clause shall only apply to indemnity sections of 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

This policy is ordinarily renewable for life except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured

a) We are NOT under any obligation to:
   i) Send renewal notice or reminders.
   ii) Renew it on same terms or premium as the expiring Policy. Any change in benefit or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority of India (IRDAI) and will be intimated to You atleast 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy. You will have the option to migrate to similar indemnity health insurance policy available with us at the time of renewal with all the accrued continuity benefits such as multiplier benefit, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines.

b) We will not apply any additional loading on your policy premium at renewal based on claim experience.

c) Sum Insured can be enhanced only at the time of renewal subject to the underwriting norms and acceptability criteria of the policy. If the insured increases the sum insured one grid up, no fresh medicals shall be required. In cases where the sum insured increase is more than one grid up, the case may be subject to medicals, the cost of such medicals would be borne by You and upon acceptance of your request We shall refund 100% of the expenses incurred on medical tests. In case of increase in the Sum Insured waiting period will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at the discretion of the company.

d) We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.

e) All applications for renewal of the Policy must be received by Us before the end of the Policy Period. A Grace Period of 30 days for renewing the Policy is available under this Policy. Any disease/ condition contracted during the Grace Period will not be covered and will be treated as a Pre-existing Condition.

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. Termination (Other Than Free Look)

i) You may terminate this Policy at any time by giving Us written notice. The cancellation shall be from the date of receipt of such written notice. Premium shall be refunded as per table below IF AND ONLY IF no claim has been made under the Policy.

1 Year Policy		2 Year Policy	
Length of time Policy in force	Refund of premium	Length of time Policy in force	Refund of premium
Upto 1 Month	75.00%	Upto 1 Month	87.50%
Upto 3 Months	50.00%	Upto 3 Months	75.00%
Upto 6 Months	25.00%	Upto 6 Months	62.50%
Exceeding 6 Months	Nil	Upto 12 Months	48.00%
		Upto 15 Months	25.00%
		Upto 18 Months	12.00%
		Exceeding 18 Months	Nil

ii) We shall terminate this Policy for the reasons as specified under aforesaid section 7 j) (Non Disclosure or Misrepresentation) & section 7 k) (Fraudulent Claims) of this Policy and such termination of the Policy shall be ab initio from the inception date or the renewal date (as the case may be), upon 30 day notice, by sending an endorsement to Your address shown in the Schedule,

s. Free Look Period

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. You can cancel Your Policy only if You have not made any claims under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of renewal of the Policy.

Section VII. 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. **Age** or **Aged** means completed years as at the Commencement Date.

Def. 3. **Alternative treatments** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Def. 4. **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. 5. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

Def. 6. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 8. **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. 9. **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. 10. **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. 11. **Cumulative Bonus (Multiplier Benefit)** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 12. **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:

1. 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 TaN0M0 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.

2. 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

3. 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.

4. 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.

5. 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 or;

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

6. 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 MRIfindings 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.

7. 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.

8. Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial 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 atleast 3 months has to be produced.

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular diseases affecting only the eye or optic nerve or vestibular functions

Def. 13. **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. 14. **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. 15. **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.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Def. 16. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 17. **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. 18. **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. 19. **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. 20. **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. 21. **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. 22. **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. 23. **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 coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

Def. 24. **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 round the clock,

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

III. has qualified Medical Practitioner(s) in charge round the clock,

IV. has a fully equipped operation theatre of its own where surgical procedures are carried out,

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

Def. 25. **Hospitalisation** 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. 26. **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. 27. **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. 28. **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. 29. **Insured Person** means You and the persons named in the Schedule.

Def. 30. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards

Def. 31. **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. 32. **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. 33. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription

Def. 34. **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. 35. **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. 36. **Medically Necessary Treatment** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 37. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

Def. 38. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

Def. 39. **Non Network Provider** means any Hospital, day care centre or other provider that is not part of the Network

Def. 40. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 41. **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. 42. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Def. 43. **Pre-existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

Def. 44. **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. 45. **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. 46. **Policy** means your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def. 47. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 48. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 49. **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. 50. **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. 51. **Room Rent** means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses

Def. 52. **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.53. **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. 54. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 55. **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. 56. **We/Our/Us** means the HDFC ERGO Health Insurance Ltd.

Def. 57. **You/Your/Policyholder** means the person named in the schedule who has concluded this policy with us.

HDFC ERGO HEALTH

Section VIII. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, You can contact HDFC ERGO Health Insurance Ltd. through:

Website : www.hdfcergohealth.com
Email : customerservice@hdfcergohealth.com
Toll Free : 1800 102 0333
Fax : 1800 425 4077
Courier : Claims Department,
HDFC ERGO Health Insurance Ltd.
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 Ltd.,
Central Processing Center, 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.

Section IX. Grievance Redressal Procedure

If you have a grievance that you wish us to redress, you may contact us with the details of Your grievance through:

Website : www.hdfcergohealth.com
Email : customerservice@hdfcergohealth.com
Toll Free : 1800 102 0333
Fax : +91 124 4584111
Courier : Any of Our Branch office or corporate office

You may also approach the grievance cell at any of our branches with the details of your grievance during our working hours from Monday to Friday.

If you are not satisfied with our redressal of your grievance through one of the above methods, you may contact our Head of Customer Service at **The Grievance Cell, HDFC ERGO Health Insurance Ltd., Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana**

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of Ombudsman offices are mention in next page.

Address & Contact Details of Ombudsmen Centres

Office of the Executive Council of Insurers' (Monitoring Body for Offices of Insurance Ombudsman) 3rd Floor, Jeevan Seva Annexe, Santacruz(West), Mumbai – 400054. **Tel:** 26106671/ 6889. **Email id:** inscoun@ecoi.co.in **Website:** www.ecoi.co.in
If you have a grievance, approach the grievance cell of Insurance Company first. If complaint is not resolved/ not satisfied/not responded for 30 days then You can approach The Office of the Insurance Ombudsman (Bimalokpal) Please visit our website for details to lodge complaint with Ombudsman.

Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, **AHMEDABAD - 380001.** **Tel:** 079-25501201/02/05/06 **Email:** bimalokpal.ahmedabad@ecoi.co.in	**Office of the Insurance Ombudsman,** 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, **BHOPAL - 462 003**. **Tel:** 0755 - 2769201/ 9202 **Fax:** 0755 - 2769203 **Email:** bimalokpal.bhopal@ecoi.co.in
Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR - 751 009.** **Tel:** 0674 - 2596455/2596003 **Fax:** 0674 - 2596429 **Email:** bimalokpal.bhubaneswar@ecoi.co.in	**Office of the Insurance Ombudsman,** SCO No.101-103,2nd Floor, Batra Building, Sector 17-D, **CHANDIGARH - 160 017.** **Tel:-** 0172 - 2706468/2772101 **Fax:** 0172 - 2708274 **Email:** bimalokpal.chandigarh@ecoi.co.in
Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI - 600 018.** **Tel:** 044 - 24333668/ 24335284 **Fax:** 044 - 24333664 **Email:** bimalokpal.chennai@ecoi.co.in	**Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Bldg.,Asaf Ali Road, **NEW DELHI - 110 002.** **Tel:** 011 - 23234057/ 23232037 **Fax:** 011 - 23230858 **Email:** bimalokpal.delhi@ecoi.co.in
Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, S.S. Road, **GUWAHATI - 781 001.** **Tel:** 0361 - 2132204/ 5 **Fax:** 0361 - 2732937 **Email:** bimalokpal.guwahati@ecoi.co.in	**Office of the Insurance Ombudsman,** 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** **Tel:** 040 - 65504123/ 23312122 **Fax:** 040 - 23376599 **Email:** bimalokpal.hyderabad@ecoi.co.in
Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., M.G. Road, **ERNAKULAM-682 015.** **Tel:** 0484 - 2358759/ 2359338 **Fax:** 0484 - 2359336 **Email:** bimalokpal.ernakulam@ecoi.co.in	**Office of the Insurance Ombudsman,** Hindustan Building. Annexe, 4th Floor, C.R.Avenue, **KOLKATA - 700072** **Tel:** 033 - 22124339/ 22124346 **Fax:** 22124341 **Email:** bimalokpal.kolkata@ecoi.co.in
Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** **Tel:** 0522 - 2231331/ 2231330 **Fax:** 0522 - 2231310 **Email:** bimalokpal.lucknow@ecoi.co.in	**Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Seva Annexe,S.V. Road, Santacruz(W), **MUMBAI-400 054.** **Tel:** 022 - 26106960/ 26106552 **Fax :** 022 - 26106052 **Email:** bimalokpal.mumbai@ecoi.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, **JAIPUR – 302 005.** **Tel:** 0141 - 2740363 **Email:** bimalokpal.jaipur@ecoi.co.in	**Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Darshan, N.C. Kelkar Road, Narayanpet **PUNE – 411 030.Tel:** 020 - 32341320 **Email:** Bimalokpal.pune@ecoi.co.in
Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, Ground Floor **BENGALURU – 560 025.** **Tel:** 080 - 26652049/ 26652048 **Email:** bimalokpal.bengaluru@ecoi.co.in	**Office of the Insurance Ombudsman,** 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, **NOIDA – 201 301.** **Tel:** 0120 - 2514250/ 51/ 53 **Email:** bimalokpal.noida@ecoi.co.in
Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, **PATNA – 800 006.** **Tel:** 0612 - 2680952 **Email id:** bimalokpal.patna@ecoi.co.in	

IRDAI REGULATION NO 5: This policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation.

Annexure I

List of excluded expenses (non-medical) under indemnity policy are uploaded on our website.
Please login to http://www.hdfcergohealth.com/download-forms/List-of-Non-Medical-Expenses.pdf

HDFC ERGO HEALTH

Optima RESTORE Individual

Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00	5.00	10.00	15.00	20.00,25.00,50.00
1a) In-patient Treatment	Covered	Covered	Covered	Covered	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 days	Covered, upto 180 days	Covered, upto 180 days	Covered, upto 180 days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered	Covered	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered	Covered	Covered	Covered
1f) Organ Donor	Covered	Covered	Covered	Covered	Covered
1g) Ambulance Cover	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation
1h) Daily Cash for choosing Shared Accommodation	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered	Covered	Covered	Covered
1j) Emergency Air Ambulance Cover	Not Covered	Not Covered	Covered	Covered	Covered
2) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
3) Preventive Health Checkup (per person)	Not Applicable	Upto Rs 1500	Upto Rs 2000	Upto Rs 4000	Upto Rs 5000
4) Multiplier Benefit	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	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	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	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	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

Optima RESTORE Family

Basic Sum Insured per Policy per Policy Year (Rs. in Lakh)	3.00	5.00	10.00	15.00	20.00,25.00,50.00
1a) In-patient Treatment	Covered	Covered	Covered	Covered	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 days	Covered, upto 180 days	Covered, upto 180 days	Covered, upto 180 days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered	Covered	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered	Covered	Covered	Covered
1f) Organ Donor	Covered	Covered	Covered	Covered	Covered
1g) Ambulance Cover	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation	Upto Rs.2,000 per Hospitalisation
1h) Daily Cash for choosing Shared Accommodation	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.800 per day, Maximum Rs.4,800	Rs.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered	Covered	Covered	Covered
1j) Emergency Air Ambulance Cover	Not Covered	Not Covered	Covered	Covered	Covered
2) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
3) Preventive Health Checkup (per policy)	Not Applicable	Upto Rs 2500	Upto Rs 5000	Upto Rs 8000	Upto Rs 10,000
4) Multiplier Benefit	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	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	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	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	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