Optima Restore

Customer Information Sheet

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

The information mentioned below is illustrative and not exhaustive. Information must be read in conjunction with the product brochures and policy document. In case of any conflict between the Key Features Document and the policy document the terms and conditions mentioned in the policy document shall prevail.

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. Emergency Ambulance -** 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. Restore Benefit -** Re-instatement of the basic sum insured if the basic sum insured and multiplier benefit has been exhausted during the policy year. The Restore Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease (including its complications) for which a claim has been paid in the current policy year If the restore sum insured is not utilised in a policy year, it shall not be carried forward to any subsequent policy year.	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 II.2
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, mental disorders, congenital internal or external diseases, defects or anomalies, genetic disorders; 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
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 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.o)
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. **Health Check-up -** At the end of a block of every continuous 2 policy years. We will pay upto the stated percentage of the Sum Insured towards cost of the medical check-up.	Section IV Section III

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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 without refund of premium.	Section VI.s)
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.apollomunichinsurance.com or e-mail Us at customerservice@apollomunichinsurance.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.

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Apollo Munich Health Insurance Co. Ltd. • 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad-500033, Andhra Pradesh • Insurance is the subject matter of solicitation • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDA Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

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OptimaRESTORE
Policy Wording

ApolloMunich HEALTH INSURANCE
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Apollo Munich Health Insurance Company Limited will cover all 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

The following benefits are available to all Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or treatment defined as a Day Care Procedure or treatment defined as Domiciliary Treatment. Any claims made under these benefits will impact eligibility for Multiplier Benefit.

We will cover the Medical Expenses for:		We will not cover treatment, costs or expenses for*: *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section V A and V C
1.	a. In-Patient Treatment Treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.	1. Prosthetics and other devices NOT implanted internally by surgery. 2. Hospitalisation for evaluation, Investigation only For example tests like Electrophysiology Study (EPS), Holter monitoring, sleep study etc are not payable. 3. Treatment availed outside India 4. Treatment at a healthcare facility which is NOT a Hospital.
	b. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation. c. Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 180 days after discharge from Hospital.	1. Claims which have NOT been admitted under 1a) and 1d) 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required. 3. 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, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement, which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an Out-patient basis is not included in the scope of this definition.	1. Out-Patient Treatment 2. Treatment at a healthcare facility which is NOT a Hospital
	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.	1. Treatment of less than 3 days. (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days) 2. Post-Hospitalisation expenses 3. The following medical conditions: a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, b. Arthritis, Gout and Rheumatism, c. Chronic Nephritis and Nephritic Syndrome, d. Diarrhoea and all type of Dysenteries including Gastroenteritis, e. Diabetes Mellitus and Insupidus, f. Epilepsy, g. Hypertension, h. Psychiatric or Psychosomatic Disorders of all kinds, i. Pyrexia of unknown origin.
	f. Organ Donor Medical treatment of the organ donor for harvesting the organ.	1. Claims which have NOT been admitted under 1a). 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 an ambulance in an emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under 1a) and 1d). 2. Non registered healthcare or ambulance service provider ambulances.

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.

Outpatient Treatment means the treatment 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 the scope and jurisdiction of licence.

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.

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	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 days of admission and discharge. 2. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit. 3. 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, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke.	1. More than one claim for this benefit in a Policy Year. 2. Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.
Section II. Restore Benefits.		
2.	If the Basic Sum Insured and multiplier benefit (if any) is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Basic Sum Insured) will be automatically available for the particular policy year, provided that: a. The Restore Sum Insured will be enforceable only after the Basic Sum Insured inclusive of the Multiplier Bonus under Section IV have been completely exhausted in that year; and b. The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section I; c. The Restore Sum Insured can be used for only future claims made by the Insured Person d. No Multiplier Bonus under Section IV will apply to the Restore Sum Insured; e. The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year; f. If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year. Incase Family Floater policy, Restore Sum Insured will be available for all Insured Persons in the Policy.	1. Illness/disease for which a claim has been paid in the current policy year under Section I.

Section III. 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 percentage (mentioned in the Schedule of Benefits) of the Basic Sum Insured for this Policy Year or the subsequent Policy Years (whichever is lower) towards the cost of a medical check-up for those Insured Persons who were insured for the number of previous Policy Years mentioned in the Schedule.

Plan	Sum Insured- 20,25,50 Lacs
Optima Restore Individual	Upto 1% of Sum Insured subject to a Maximum of Rs.10,000 per Insured Person, only once at the end of a block of every continuous two policy years
Optima Restore Family	Upto 1% of Sum Insured per Policy subject to a Maximum of Rs. 10,000 per policy, only once at the end of a block of every continuous two policy years

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Section IV. Multiplier Benefit

a) If no claim has been made in respect of Section I under this Policy and the Policy is renewed with Us without any break, We will apply a bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 50% of the Basic Sum Insured for this Policy Year. The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

b) In Family Floater policy,

i. The multiplier benefit shall be available on floater basis and accrue only if no claims have been made in respect of any Insured Person during the expiring Policy Year.

ii. Accrued Multiplier benefit is available to all insured persons under the policy

c) 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.

d) If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated 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 least multiplier bonus amongst all the Insured Persons.

e) 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.

f) 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 treatment and admission within 30 days from Policy Commencement Date except claims arising due to an Accident.

ii) A waiting period of 24 months from policy Commencement Date shall apply to the treatment, whether medical or surgical, of the disease/conditions mentioned below. Additionally the 24 months waiting period shall also be applicable to all the surgical procedures mentioned under surgeries in the following table, irrespective of the disease/condition for which the surgery is done, except claims payable due to the occurrence of cancer.

Sl No	Organ / Organ System	Illness	Treatment
a	ENT	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Nasal concha resection
b	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease • Fibroids (fibromyoma)	• Dilatation and curettage (D&C) • Myomectomy for fibroids
c	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis	• Surgery for prolapsed inter vertebral disk • Joint replacement surgeries
Sl No	Organ / Organ System	Illness	Treatment
d	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Pancreatitis • Fissure/ fistula in anus, hemorrhoids, pilonidal sinus • Ulcer and erosion of stomach and duodenum • Gastro Esophageal Reflux Disorder (GERD) • All forms of cirrhosis (Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses	• Cholecystectomy • Surgery of hernia
e	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f	Eye	• Cataract	Nil
g	Others	Nil	• Surgery of varicose veins and varicose ulcers
h	General (Applicable to all organ systems/ organs/ disciplines whether or not described above)	• Internal tumors, cysts, nodules, polyps, skin tumors	• NIL

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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 V A i), ii) and iii) of the Policy stand deleted; And :
   b) The waiting periods specified in the Section V 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 and 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 in respect of any Insured Person directly or indirectly for, 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) Breach of law:

Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane.

iii) 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

iv) Substance abuse and de-addiction programs:

Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.

v) Treatment of obesity and any weight control program.

vi) Treatment for correction of eye sight due to refractive error.

vii) 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.

viii) 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. Experimental, investigational or unproven treatment devices and pharmacological regimens.
   d. Admission primarily for diagnostic purposes not related to Illness for which Hospitalisation has been done.
   e. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.
   f. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
   g. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) 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.
   h. 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.
   i. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).
   j. Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea.
   k. Congenital internal or external diseases, defects or anomalies, genetic disorders.
   l. Stem cell Therapy or surgery, or growth hormone therapy.
   m. Venereal disease, sexually transmitted disease or illness;
   n. "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.
   o. Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only.
   p. Treatment for sterility, infertility, sub-fertility or other related conditions and complications arising out of the same. Assisted conception, surrogate or vicarious pregnancy, birth control, and similar procedures including complications arising out of the same.
   q. Expenses for organ donor screening, or save as and to the extent provided for in 1f), the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery).
   r. 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.
   s. Dental treatment and surgery of any kind, unless requiring Hospitalisation.

ix) Unnecessary medical expenses:
   a. Items of personal comfort and convenience including but not limited

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to television (wherever specifically charged for), charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

b. Vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

x) Specified healthcare providers (Hospitals /Medical Practitioners)

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

b. 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.

c. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription.

d. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

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

xii) Any non medical expenses mentioned in Annexure I.

xiii) The costs of any procedure or treatment by any person 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.

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) 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.

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 V A i),ii) & iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

e. Notification of Claim

	Treatment, Consultation or Procedure:	Apollo Munich must be notified:
i)	Any treatment for which a claim may be made requires Hospitalisation.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	Any treatment for which a claim may be made requires Hospitalisation in an Emergency.	Within 24 hours of the start of the Insured Person's Hospitalisation.

f. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	Notice period for the Insured Person to take advantage of the cashless service*:
i)	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.	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	Any treatment, consultation or procedure for which a claim may be made 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 of the start of the Insured Person's Hospitalisation.

g. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will 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 either 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 with detailed breakup of charges(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

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claimed which will then become Our property.

iii) Original payment receipts

iv) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.

v) Discharge Summary containing details of Date of admission and dischargedetailed clinical history, detailed past history, procedure details and details of treatment taken

vi) Invoice/Sticker of the Implants.

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

viii) A detailed list of the individual medical services and treatments provided and a unit price for each.

ix) 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 Medical Practitioner's invoice.

x) Obs history/ Antenatal card

xi) Previous treatment record along with reports, if any

xii) Indoor case papers

xiii) Treating doctors certificate regarding the duration & etiology

xiv) MLC/ FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent, in case of Accidental injury

h. The Insured Person will 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 will 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 has 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. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).No assignment of this Policy or the benefits thereunder shall be permitted.

iii) 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.

iv) 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 submission of all necessary documents / 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 IRDA (Protection of Policyholders Regulation), 2002. 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 IRDA (Protection of Policyholders Regulation), 2002, we shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

v) In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.

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 without refunding the Premium amount; 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 dishonest or fraudulent, or is supported by any dishonest or 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 without refund of premium; 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. Subrogation

The Insured Person must do all acts and things that We may necessarily and reasonably require to enforce/ secure any civil / criminal rights and remedies or to obtain relief / indemnity from any other party because of making reimbursement under the Policy. This would be irrespective of whether such necessity has arisen before or after the reimbursement. These subrogation rights must NOT be prejudiced in any manner by the Insured Person. The Insured Person must provide Us with whatever assistance or cooperation is required to enforce such rights. We would deduct any amounts paid or payable and expenses of effecting recovery from any recovery that We make pursuant to this clause and pay the balance to You. This clause is only applicable to indemnity policies and benefits.

n. 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.

o. Renewal

This Policy is ordinarily renewable for life unless the Insured Person or anyone acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or there has been any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

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 and will be intimated to You atleast 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate

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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.

p. 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.

q. 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.

r. 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.

s. Termination

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 VI j) (Non Disclosure or Misrepresentation) & section VI k) (Dishonest or 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, without refunding the Premium amount.

t. 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 it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been 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 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** refers to a condition(s) 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. **Copayment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Def. 11. **Cumulative Bonus (Multiplier Benefit)** means any increase 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, 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 only:

i) Cancer of specified severity:

A malignant tumour characterised by the uncontrolled growth &

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spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection.

ii) Open Chest CABG:

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The Diagnosis must be supported by coronary angiography and realisation of the surgery has to be confirmed by a specialist Medical Practitioner

The following are xxcluded:

- Angioplasty and / or Any other intra-arterial procedures
- Any Key-hole surgery or laser surgery

iii) First Heart Attack of Specified Severity:

The first occurrence of 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 this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
- New characteristic electrocardiogram changes.
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

  The following are excluded :
- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.
- Other acute Coronary Syndromes.
- Any type of angina pectoris

iv) Kidney Failure requiring Regular Dialysis:

End stage renal disease presented 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.

The diagnosis has to be confirmed by a specialist Medical Practitioner

v) Major Organ/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

- One of the following human organs - heart, lung, liver, pancreas, kidney, that resulted from irreversible end-stage failure of the relevant organ or;
- Human bone marrow using haematopoietic stem cells.

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

  The following are excluded:
- Other Stem-cell transplants
- Where only islets of langerhans are transplanted

vi) Multiple Sclerosis with Persisting Symptoms:

The definite occurrence of Multiple Sclerosis.The diagnosis must be supported by all of the following:

- Investigation including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple Sclerosis.
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months.
- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast 1 month apart.

  Excluded is:
- Other causes of neurological damage such as SLE and HIV are excluded

vii) Permanent Paralysis of Limbs:

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

viii) Stroke resulting in Permanent Symptoms:

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

The 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:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- 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 within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under-

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- 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. **Dental treatment** means treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

Def. 16. **Dependents** means only the family members listed below:

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

Def. 19. **Emergency Care** means management for a severe 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. 20. **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. 21. **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. 22. **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:

- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 23. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum of 24 In patient care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 24. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

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

b) Chronic Condition means a disease, illness, or injury that has one or more o f the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief o f symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it comes back or is likely to come back.

Def. 25. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 26. **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.

Def. 27. **Insured Person** means You and the persons named in the Schedule.

Def. 28. **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. 29. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 30. **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.

a) Pre- Hospitalisation Medical Expenses means the Medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company

b) Post- Hospitalisation Medical Expenses means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:

iii. Such Medical Expenses are incurred for the same condition for which the insured person's Hospitalisation was required and

iv. The inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance company

Def. 31. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

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

Def. 32. **Network Provider** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

Def. 33. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network

Def. 34. **Notification of Claim** means the process of notifying a claim to the

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insurer or TPA by specifying the timeliness as well as the address / telephone number to which it should be notified.

Def. 35. **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. 36. **Pre-existing Condition** means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first policy issued by the insurer.

Def. 37. **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. 38. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 39. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 40. **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. 41. **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. 42. **Room Rent** means the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses.

Def. 43. **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 all waiting periods

Def. 44. **Subrogation** means the the right o f the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

Def. 45. **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 of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 46. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 47. **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. 48. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited.

Def. 49. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section VIII. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, You can contact Apollo Munich through:

Website : www.apollomunichinsurance.com
Email : customerservice@apollomunichinsurance.com
Toll Free : 1800 - 102 - 0333
Fax : 1800 - 425 - 4077
Courier : Claims Department,
Apollo Munich Health Insurance Co. Ltd.,
Ground Floor, Srinilaya - Cyber Spazio,
Road No. 2, Banjara Hills,
Hyderabad-500034, Andhra Pradesh.

or : Claims Department,
Apollo Munich Health Insurance Company Ltd.,
2nd & 3rd Floor, iLABS Centre, Plot No. 404-405,
Udyog Vihar, Phase-III, Gurgaon-122016, Haryana.

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.apollomunichinsurance.com
Email : customerservice@apollomunichinsurance.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, Apollo Munich Health Insurance Company Ltd., 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 mentioned next page.

Ombudsman Offices

Jurisdiction	Office Address
Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu	Shri P. Ramamoorthy (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.:- 079-27546840 Fax : 079-27546142 Email: ins.omb@rediffmail.com
Madhya Pradesh & Chhattisgarh	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P.)-462 023.** Tel.:- 0755-2569201 Fax : 0755-2769203 Email: bimalokpalbhopal@airtelmail.in
Orissa	Shri B. P. Parija (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.:- 0674-2596455 Fax : 0674-2596429 Email: ioobbsr@dataone.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh	Shri Manik Sonawane (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, **CHANDIGARH-160 017.** Tel.:- 0172-2706468 Fax : 0172-2708274 Email: ombchd@yahoo.co.in
Tamil Nadu, UT-Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.:- 044-24333668 /5284 Fax : 044-24333664 Email: chennaiinsuranceombudsman@gmail.com
Delhi & Rajasthan	Shri Surendra Pal Singh (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI-110 002.** Tel.:- 011-23239633 Fax : 011-23230858 Email: iobdelraj@rediffmail.com

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Jurisdiction	Office Address
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Shri D.C. Choudhury (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, **GUWAHATI-781 001 (ASSAM).** Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: ombudsmanghy@rediffmail.com
Andhra Pradesh, Karnataka and UT of Yanam - a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** Tel : 040-65504123 Fax: 040-23376599 Email: insombudhyd@gmail.com
Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	Shri R. Jyothindranathan (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel : 0484-2358759 Fax : 0484-2359336 Email: iokochi@asianetindia.com
West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim	Ms. Manika Datta (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **KOLKATTA - 700 072.** Tel: 033 22124346/(40) Fax: 033 22124341 Email: iombsbpa@bsnl.in
Uttar Pradesh and Uttaranchal	Shri G. B. Pande (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** Tel : 0522 -2231331 Fax : 0522-2231310 Email: insombudsman@rediffmail.com
Maharashtra, Goa	Insurance Ombudsman, Office of the Insurance Ombudsman, S.V. Road, Santacruz(W), **MUMBAI-400 054.** Tel : 022-26106928 Fax : 022-26106052 Email: ombudsmanmumbai@gmail.com

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

Annexure I

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
1	HAIR REMOVAL CREAM CHARGES	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	LEGGINGS	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.

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S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
30	FOOT COVER	Not Payable
31	GOWN	Not Payable
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUZE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures may be considered
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUB-FERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/ AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY AND STORAGE	Not Payable except Bone Marrow Transplantation where covered by policy
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately

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S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
82	BOYLES APPARATUS CHARGES	Part of OT Charges, not seperately
83	X-RAY FILM	Payable under Radiology Charges, not as consumable
84	SPUTUM CUP	Payable under Investigation Charges, not as consumable
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	ANTISEPTIC OR DISINFECTANT LOTION	Not Payable - Part of Dressing charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable - Part of Dressing charges
89	COTTON BANDAGE	Not Payable - Part of Dressing charges
90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
	ELEMENTS OF ROOM CHARGE	
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge, Not payable separately

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry/ Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable - Part of Room Charges
	ADMINISTRATIVE OR NON-MEDICAL CHARGE	
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable

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S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
	EXTERNAL DURABLE DEVICES	
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not payable
135	INFUSION PUMP - COST	Device not payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/ quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHIELD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
156	BETADINE \ HYDROGEN PEROXIDE\ SPIRIT\\DETTOL \SAVLON\ DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post Hospitalisation nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES-DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE TABLET	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	DIGENE GEL/ ANTACID GEL	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164	HIV KIT	Payable - payable Pre operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during Hospitalisation is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost

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S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
	OTHERS	
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVD requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable-Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.

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OptimaRESTORE
Policy Wording

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

OptimaRESTORE 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
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 Days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered
1f) Organ Donor	Covered	Covered
1g) Emergency Ambulance	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.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered
2) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
3) Health Checkup	Not Covered	Upto 1% of Sum Insured subject to a Maximum of Rs.10,000 per Insured Person, only once at the end of a block of every continuous two policy years
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

OptimaRESTORE 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
1b) Pre-Hospitalization	Covered, upto 60 Days	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 180 Days	Covered, upto 180 Days
1d) Day Care Procedures	Covered	Covered
1e) Domiciliary Treatment	Covered	Covered
1f) Organ Donor	Covered	Covered
1g) Emergency Ambulance	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.1000 per day, Maximum Rs.6,000
1i) E-Opinion in respect of a Critical Illness	Covered	Covered
2) Restore Benefit	Equal to 100% of Basic Sum Insured	Equal to 100% of Basic Sum Insured
3) Health Checkup	Not Covered	Upto 1% of Sum Insured per Policy subject to a Maximum of Rs. 10,000 per policy, only once at the end of a block of every continuous two policy years
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

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Apollo Munich Health Insurance Co. Ltd. • 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad-500033, Andhra Pradesh • Insurance is the subject matter of solicitation • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDA Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

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OptimaRESTORE

Claim Procedure

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

Please review your Optima Restore policy and familiarize yourself with the benefits available and the exclusions.
To help us to provide you with fast and efficient service, We kindly ask you to note the following.

1. We recommend that you keep copies of all documents submitted Apollo Munich.
2. Please quote your member ID/policy number in all your correspondences.

Claim Procedure for Hospitalisation related benefits

What do I do in case of a claim or any assistance?

Intimation & Assistance	Procedure for Reimbursement of Medical Expenses	Procedure to avail Cashless facility
Please contact us atleast 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact us 24 hours of the event. We can be contacted through: - **Website:** www.apollomunichinsurance.com - **Toll Free:** 1800-102- 0333 - **Fax:** 1800- 425- 4077 - **Courier:** Claims Department, Apollo Munich Health Insurance Co. Ltd., Ground floor, Srinilaya – Cyber Spazio Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034. or : Claims Department, Apollo Munich Health Insurance Co. Ltd., 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana. Please use the Claim Intimation Form available at our website for intimation of a claim.	• Please send the duly signed claim form and all the information/documents mentioned* therein to us within 15 days of the completion of the treatment. * Please refer to claim form for complete documentation. • If there is any deficiency in the documents/ information submitted by you, We will send the deficiency letter within 7 days of receipt of the claim documents. • On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. **Note: Payment will only be made for items covered under your policy and upto the limits therein.**	• For any emergency Hospitalisation, We must be informed no later than 24 hours after hospitalization. • For any planned hospitalization, kindly seek cashless authorization from us atleast 48 hours prior to the hospitalization. • We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents. • 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 6 hours. **Note:** • **Insured person is entitled for cashless only in our empanelled hospitals.** • **Please refer to the list of empanelled hospitals on our website Or the list provided in the welcome kit.** • **Please refer to the list of non-medical expenses not covered in the policy in annexure I of policy wordings.** • **Rejection of cashless in no way indicates rejection of the claim.**

Intimation & Assistance	Claims Procedure
Please contact Us within 14 days of diagnosis of first occurrence of Critical Illness. - **Website:** www.apollomunichinsurance.com - **Toll Free:** 1800-102- 0333 - **Fax:** 1800- 425- 4077 - **Courier:** Claims Department, Apollo Munich Health Insurance Co. Ltd., Ground floor, Srinilaya – Cyber Spazio Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034. or : Claims Department, Apollo Munich Health Insurance Co. Ltd., 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana. Please use the Claim Intimation Form available at our website for intimation of a claim.	**Critical Illness** • You must intimate us within 14 days of diagnosis of first occurrence of Critical Illness • You must submit a duly filled claim form along with specified documents within 45 days of completion of survival period for the Critical Illness against which the claim is made • If there is any deficiency in the documents/information submitted by You, we will send the deficiency letter within 7 days of receipt of the claim documents • Any additional information requested must be submitted within 15 days of our request • On receipt of the complete set of claim documents, We will make the payment for the admissible amount, along with a settlement statement within 30 days **E-opinion** • Please submit duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) at any of our Branch Office • You need to select Our Panel Doctor from whom You would prefer to take the e-opinion. (Please refer Our Website or call at 24X 7 Toll Free line to obtain the list of Our Panel Doctors) • On receipt of the complete set of documents We will forward the same to the concerned doctor. • The E-Opinion will be forwarded to the member within 7 working days of the receipt of the complete set of documents.

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-1020-333 or log on to our website www.apollomunichinsurance.com or email us at customerservice@apollomunichinsurance.com

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

Apollo Munich Health Insurance Co. Ltd. • 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad-500033, Andhra Pradesh • Insurance is the subject matter of solicitation • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDA Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

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