THE ORIENTAL INSURANCE COMPANY LIMITED
Regd. Office: Oriental House, A-25/27, Asaf Ali Road, New Delhi-110002 CIN No.U66010DL1947GOI007158

ORIENTAL MEDICLAIM INSURANCE POLICY (INDIVIDUAL)

PROSPECTUS

1. SALIENT FEATURES OF THE POLICY

- The Policy term is one year and is available to any proposer between the ages of 18 to 65 years for treatment taken in India. The proposer can also get his family covered (as defined under 2.1).
- Maximum Entry age for any member, is 65years however, this can be extended up to 70 years. In such case, an additional premium of 10% (including on all future renewals) will be charged on applicable rates, including on Optional PA cover.
- Sum Insured (SI) available from Rs.1lac to Rs.50lacs.
- Pre-existing diseases covered after four consecutive renewals. Lifelong renewals allowed.
- Family discount of 10% (including on PA cover) if more than one person is covered under the policy.
- Option of voluntary co-payment of 10% and 20% with corresponding premium discount of 10% and 20% respectively on SI of Rs.2lacs and above. Voluntary co-payment does not apply on PA section.
- No medical examination for person's up to the age of 55 years.
- In case of fresh covers, 50% of the Pre-insurance medical check-up cost reimbursable, subject to acceptance of the Proposal.
- Daily Hospital Cash allowance in case of more than 2 days of continuous hospitalization.
- Hospitalization expenses incurred for donating an organ by the donor (excluding cost of organ) to the insured person, is covered
- Ambulance charges covered
- Personal Accident available on optional basis for SI from Rs.2lacs to Rs.10lacs.
- In-built covers – Medical second opinion, Air ambulance, OPD benefit for dental and ophthalmic cover and additional sum insured for critical illness available to insured persons with sum insured slab of Rs. 25.0 lac and above.
- Free Look Period- A period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and return the same, if not acceptable.
- Grace period of 30 days is allowed for payment of renewal premium.
- Premium adjustment at renewal, for the duration of OMP cover taken from Oriental.
- Discount of 5.5% in premium if TPA services not opted for.
- A discount of 10 %(maximum Rs. 2000/-) on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.

2. OTHER SALIENT FEATURES

2.1 DEFINITION OF FAMILY consists of the proposer and any one or more of the family members as mentioned below:
(i) Legally wedded spouse.

(ii) Dependent Children (i.e. natural or legally adopted) between the ages 3 months to 18 years. However male child can be covered up to the age of 25 years if he is a bonafide regular student and financially dependent on the proposer. Female child can be covered until she gets married. Divorced and widowed daughters, are also eligible for coverage under the policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
(iii) Parents / Parents-in-law (either of them).
(iv) Unmarried siblings, if financially dependent on the proposer.

2.1 **SUM INSURED** Minimum sum insured is Rs 100,000 and in multiples of Rs 50,000 up to Rs5, 00,000. Beyond the Sum Insured of Rs. 5, 00,000 in multiples of Rs. 1,00,000 Up to Rs 10,00,000. Thereafter the sum insured slabs available are Rs. 12, 15, 18, 20, 25, 30, 40 and 50 lakhs. The sum insured of each of the insured person in a policy may vary. Maximum sum insured that can be opted by a person joining after the age of 65 years is Rs.5 lakhs.

2.2 **ENHANCEMENT OF SUM INSURED:** The insured may seek enhancement of Sum Insured in writing before payment of premium for renewal. Before granting such request for enhancement of Sum Insured, if deemed necessary by the Underwriting Authority. The Company has the right to have the insured examined by a Medical Practitioner authorized by the Company or the TPA. The cost of such medical examination will be borne by the insured/s.The consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner.

Enhancement of Sum Insured shall be allowed based on the following table:

Age<=45 years	Enhancement up to maximum Sum Insured available without Medical Examination.
Age 46-60 Years	Enhancement by two slabs without Medical Examination.
Age 61-65 Years	Enhancement by one slab without Medical Examination.
Age above 65 Years	Enhancement by one slab with Medical Examination.

For those Insured Person/s who had undergone Hospitalization in the preceding two years, sum insured enhancement up to one step higher from the current Sum Insured only to be allowed. In respect of any increase in Sum Insured, exclusion 5.1, 5.2 and 5.3 would apply to the additional Sum Insured from the date of such increase.

2.3 PRE -ACCEPTANCE MEDICAL CHECKUP: Any person beyond 55 years of age proposing to take insurance cover has to submit following medical reports from listed Diagnostic Centre or any other medical report(s) required by the company in case of fresh proposal or in case of renewal where there is a break in policy period. This list is available with the underwriting office from where the policy is intended to be taken, and also displayed on Company's website. The cost shall be borne by the insured.

1 PHYSICAL EXAMINATION
2 URINE (MICROALBUMIN UREA)
3 GLYCOCYLATED HAEMOGLOBIN
4 ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)
5 X RAY BOTH KNEES (ANTEPOSTERIOR AND LATREL)
6 COMPLETE EYE TEST INCLUDING FUNDUS ETC
7 STRESS TEST (TMT)

In case of fresh proposals 50% cost of Medical Checkup after acceptance of the proposal shall be reimbursed by the Company. This benefit will also be allowed in cases where continuity benefits are not restored and the policy is treated as fresh (and not as renewal) after the break in policy period.

3. DEFINITIONS

STANDARD DEFINITIONS

3.1 **ACCIDENT** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 **AMBULANCE SERVICES** means ambulance service charges reasonably and necessarily incurred in shifting the Insured Person from residence to Hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the Hospitalization expenses are admissible under the Policy.

3.3 **ANY ONE ILLNESS** Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

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

3.5 **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: which is not in the visible and accessible parts of the body.
B. External Congenital Anomaly: which is in the visible and accessible parts of the body.

3.6 **CONDITION PRECEDENT** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

3.7 **CO-PAYMENT** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

3.8 **CONTRIBUTION** is 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 rate able proportion of Sum Insured. If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

A. is fixed in nature;
B. does not have any relation to the treatment costs;

3.9 **DAY CARE CENTRE** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-

A. has qualified nursing staff under its employment;
B. has qualified medical practitioner/s in charge;
C. has fully equipped operation theatre of its own where surgical procedures are carried out;
D. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

3.10 **DAY CARE TREATMENT** means medical treatment, and/or surgical procedure which is:

A. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs. because Of technological advancement, and

B. Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list)

3.11 **DENTAL TREATMENT** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.12 **DOMICILIARY HOSPITALISATION** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

A. the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
B. The patient takes treatment at home on account of non-availability of room in a hospital.

3.13 **FAMILY** consists of the Insured and/ or anyone or more of the family members as mentioned below:

A. Legally wedded spouse.
B. Dependent Children (i.e. natural or legally adopted) between the ages 91daysto 18 years. However male child can be covered up to the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
C. Parents / Parents-in-law (either of them).
D. Unmarried siblings, if financially dependent.

3.14 **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.

3.15 **HOSPITAL/NURSING HOME** A 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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

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

*Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

- The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002

- The Bombay Nursing Homes Registration Act, 1949
- The Delhi Nursing Home Registration Act, 1953
- The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (RagistrikaranTathaAnugyapan) Adhiniyam, 1973.
- The Manipur Homes and Clinics Registration Act, 1992
- The Nagaland Health Care Establishments Act, 1997
- The Orissa Clinical Establishments (Control and Regulations) Act, 1990
- The Punjab State Nursing Home Registration Act, 1991
- The West Bengal Clinical Establishment Act, 1950

3.16 **AYUSH HOSPITAL** is a healthcare facility wherein medical/surgical/para- surgical treatment procedures and interventions are carried out by AYUSH Medical Practioner(s) comprising of any of the following:

A. Central or State Government AYUSH Hospital; or
B. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
C. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

    i. Having at least five in- patient beds;
    ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.17 **AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner (s) in charge.
b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.18 **HOSPITALISATION** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

3.19 **INSURED PERSON** means person(s) named as Insured Person (s) in the schedule of the Policy

3.20 **ILLNESS** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

A. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
B. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or

more of the following characteristics:

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

3.21 **I .D. CARD** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

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

3.23 **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.

3.24 **IN-PATIENT** means an Insured Person who is admitted to Hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / Illness / disease / Injury / accident during the currency of the Policy.

3.25 **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.

3.26 **ICU (INTENSIVE CARE UNIT) CHARGES** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

3.27 **MATERNITY EXPENSES** shall include

A. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during Hospitalization
B. Expenses towards lawful medical termination of pregnancy during the Policy Period.

3.28 **MEDICAL ADVICE** Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

3.29 **MEDICAL EXPENSES** 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.

3.30 **MEDICAL PRACTITIONER** Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

3.31 **MEDICALLY NECESSARY TREATMENT** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

A. is required for the medical management of the illness or injury suffered by the insured;
B. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
C. must have been prescribed by a medical practitioner;
D. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.32 **NEW BORN BABY** means baby born during the Policy Period and is aged upto90 days.

3.33 **NETWORK PROVIDER** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

3.34 **NON-NETWORK** means any hospital, day care centre or other provider that is not part of the network.

3.35 **NOTIFICATION OF CLAIM** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

3.36 **OPHTHALMIC COVER** It covers Ophthalmic ailments arising out of trauma/ infection/ age related diseases/ foreign body removals and excludes cosmetic eye surgeries including Lasik, cost of spectacles and contact lenses.

3.37 **OUT-PATIENT TREATMENT** is one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

3.38 **PRE-HOSPITALISATION MEDICALEXPENSES** means medical expenses incurred during the period up to 30 days prior to the date of admission in the Hospital, provided that:
A. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
B. the In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.39 **POST-HOSPITALISATION EXPENSES** means medical expenses incurred for a period up to 60 days from the date of discharge from the Hospital, provided that:
A. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
B. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.40 **PRE-EXISTING DISEASE (PED)** means any condition, ailment, injury or disease:
A. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer, or its reinstatement.
B. for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement,

3.41 **POLICY PERIOD** means the period of coverage as mentioned in the schedule.

3.42 **QUALIFIED NURSE** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

3.43 **REASONABLE AND CUSTOMARY CHARGES** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury

involved.

3.44 **RENEWAL** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.45 **ROOM RENT** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expense.

3.46 **SURGERY/ SURGICAL OPERATION** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

3.47 **THIRD PARTY ADMINISTRATOR (TPA)** means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

3.48 **UNPROVEN/EXPERIMENTAL TREATMENT** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

3.49 **MIGRATION** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

3.50 **PORTABILITY** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for preexisting conditions and time bound exclusions, from one insurer to another insurer.

3.51 **EMERGENCY CARE** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

SPECIFIC DEFINITIONS

3.52 **MENTAL ILLNESS** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

3.53 **MENTAL HEALTH ESTABLISHMENT** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends.

3.54 **MENTAL HEALTH PROFESSIONAL**

A. a psychiatrist or
B. a professional registered with the concerned State Authority under section 55; or
C. a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvum Manas Roga or a post- graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post- graduate degree (Siddha) in SirappuMaruthuvam;

3.55 **DAILY HOSPITAL CASH ALLOWANCE**

When an insured person is hospitalized and a claim is admitted under the policy, then the insured person shall be paid a daily cash allowance as specified in section 3.1(vi) . However, a deductible of 2 days per hospitalization shall apply, i.e. Daily cash allowance will become payable from the third day onwards of continuous hospitalization.

4. BENEFITS COVERED UNDER THE POLICY

4.1 COVERAGE The policy covers reasonable and customary charges in respect of Hospitalization and / or Domiciliary Hospitalization for medically necessary treatment only for illness / diseases contracted or injury sustained by the Insured Person(s) during the policy period, up to the limit of Sum Insured (SI), as detailed below:

Sl. No	Expenses covered	Limits of covered Expenses
A.	HOSPITALISATION BENEFITS	
i.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	Not exceeding 1 % of the Sum Insured per day
ii.	Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.*	Not exceeding 2% of the Sum Insured per day.
iii.	Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of Sum Insured subject to “a” and “b” below
iv.	Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances,Medicines &Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker,Artificial Limbs and similar expenses.	As per the limits of Sum Insured subject to “a” and “b” below
	a. Number of days of stay under ‘i’ above should not exceed total number of days of admission in the Hospital. All related expenses (including iii & iv above) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This will not apply on medicines / pharmaceuticals and body implants.	
	b. Any expenses in excess of reasonable and customary charges as defined under 3.43, or, in excess of the negotiated prices (in case of network hospitals) shall not be borne by the insurer.	
v.	Ambulance service charges as herein after defined.	Rs.2,000 OR 1% of the sum insured whichever is less per hospitalization subject to aggregate expenses not exceeding Rs. 4,000 under the policy.

vi.	Daily Hospital Cash Allowance as hereinafter defined. (Refer clause 3.55)	0.1% of the sum insured per day subject to maximum of 6 days per insured person during the entire policy period. Deductible of 2 days shall apply for each hospitalization.
vii.	Pre and Post Hospitalization expenses	Medical expenses incurred 30 days prior to Hospitalization and up to 60 days post Hospitalization.
	1. The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda,Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.	
	2. Relaxation to 24 hours minimum duration for Hospitalization is allowed in	
	a. Day care procedures / surgeries (Appendix I) where such treatment is taken by an Insured Person in a Hospital / day care centre(but not the Out-patient department of a Hospital),Or	
	b. Any other day care treatment as mentioned in clause 3.10 and for which prior approval from Company / TPA is obtained in writing.	
B.	DOMICILIARY HOSPITALISATION BENEFITS	
i.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines &Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	20% of the Sum Insured subject to maximum Rs.50,000 per Insured Person, during the entire policy period.
ii.	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)	Maximum Rs.5,000/- actually incurred on immunization injections in any one Policy Period. This will be part of Domiciliary Hospitalization limits as specified. For the purpose of this clause the conditions for Domiciliary Hospitalization benefit shall not apply.

4.1.1 DOMICILIARY HOSPITALIZATION benefit shall, however, not cover expenses in any of the following cases:

A. if the treatment lasts for a period of three days or less

B. incurred on treatment of any of the following diseases:

i. Asthma
ii. Bronchitis
iii. Chronic Nephritis and Nephritic Syndrome
iv. Diarrhea and all types of Dysenteries including Gastro-enteritis
v. Diabetes Mellitus and Insipidus
vi. Epilepsy
vii. Hypertension
viii. Influenza, Cough and Cold
ix. Pyrexia of unknown origin for less than 10days
x. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis
xi. Arthritis, Gout and Rheumatism.

4.1.2 DONOR EXPENSES: The policy covers in-patient hospitalization Medical expenses in respect of organ donor provided that the donation conforms to the Transplantation of Human Organs Act 1994(amended) and other applicable laws and rules and

I. The organ donated is for the use of the insured person who has been medically advised to undergo organ transplant
II. The claim of the insured person is admissible under the hospitalization section of the policy.

The policy does not cover:

a. Cost directly or indirectly associated with the acquisition of the organ and/or cost of organ.
b. cost towards donor screening
c. Any pre and post hospitalization medical expenses of the donor.
d. Any other medical treatment or complication consequent to organ harvesting, in respect of the donor.

Company's overall Liability in respect of all claims admitted under this section during the Policy period shall not exceed the Sum Insured of the Insured Person mentioned in the Schedule.

4.1.3 VOLUNTARY CO-PAYMENT: (OPTIONAL)

i. If the insured opts for a Co-payment of 10% or 20%, he is eligible for a corresponding premium discount of 10% and 20% respectively. This option is available only for insured person(s) having Sum Insured of Rs.2 lakhs and above. Co-payment cannot be opted on selective basis. All insured persons under a policy have to compulsorily opt for the same (except for insured persons with Sum Insured below Rs.2lacs, where Co-payment option is not available), and the Co-payment percentage has to be uniform across all insured persons.
ii. Co-payment is applicable on each and every claim, which means the insured shall bear 10% / 20% (as opted by him) of each and every admissible claim.

4.1.4 PERSONAL ACCIDENT (as defined under Clause 4.1.6) **Optional Cover (available on payment of additional premium)** Sum insured in multiples of Rs. 2, 00,000 up to Rs.10, 00,000 per insured person above 18yrs of age. However for persons below 18 years of age, maximum coverage of Rs.4lacs is allowed.

4.1.5 Following additional in-built covers are available to insured persons with sum insured of Rs. 25.0 lakhs and above, except for the item under sl. No. 1 and 3, below which is applicable as per sum insured slabs therein.

1	Medical Second Opinion for 11 below mentioned specified major Illnesses - taken from anywhere in the world.	The benefit will be available for sum insured Rs. 12.0 lakhs and above. The benefit limits are as below:- 1.Maximum Rs.15, 000 in a Policy period, for SI up to Rs. 20.0 lakhs. 2.Maximum Rs.25,000 in a Policy period for SI above Rs. 20.0 lakhs and up to Rs. 50.0 lakhs
2	Air Ambulance Cover	Maximum upto 5% of the SI for medical emergency cases only. The benefit will be available for sum insured Rs. 25.0 lakhs and above.
3	Accidental Death Benefit and Total Permanent Disability cover	10% of Sum Insured. The benefit will be available for sum insured Rs. 12.0 lakhs and above.
4	OPD benefit for Dental and Ophthalmic cover	Maximum Rs. 5,000/- on reimbursement basis in a block of every three years. The benefit will be available for sum insured Rs. 25.0 lakhs and above.
5	Additional Sum Insured for critical illnesses	Additional 10% of the Sum Insured. The benefit will be available for sum insured Rs. 25.0 lakhs and above.

MEDICAL SECOND OPINION - If the Insured Person is diagnosed with one of the specified major Illnesses listed below, and takes Medical Second Opinion (including opinion obtained from overseas) whether before starting the treatment or during the course of treatment, the Policy covers Medical Expert's fees to the extent in the clause 3.1.5. Claim under this clause would be admissible subject to the Hospitalization claim being admissible. This expense is payable only once per Illness per Insured Person during the life time of the Insured Person.

Major Illnesses covered:

i. Cancer
ii. Renal Disease
iii. Stroke resulting in permanent symptoms
iv. Coma
v. All Cardiac conditions/surgeries
vi. Major Organ / Bone Marrow transplantation
vii. Paralysis of limbs
viii. Motor Neuron disease
ix. All Brain related conditions/surgeries
x. Multiple Sclerosis
xi. Liver failure

AIR AMBULANCE COVER: The policy covers Air Ambulance cost maximum up to 5% of the policy sum insured, provided that:

i. This cover is available only for life threatening medical emergency condition/s which requires immediate and rapid ambulance transportation for hospitalization and medical care.
ii. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency.
iii. It is prescribed by the Medical Practitioner.
iv. The insured person is in India and the
v. The cover will be available in case of the following ailments:-
- Cardio – Vascular diseases
- Central nervous system related cases
- Accidental Trauma Cases

vi. This cover can be availed only once during the entire policy lifetime.
vii. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

ACCIDENTAL DEATH BENEFIT AND TOTAL PERMANENT DISABILITY: If an insured person suffers an Accident during the policy period and this is the sole and direct cause of his death OR total permanent disability within 365 days from the date of the accident, then the policy will pay a fixed amount of 10% of the base sum insured. This benefit is not applicable for the dependent children covered in the policy.

OPD BENEFIT FOR DENTAL AND OPHTHALMIC COVER: The policy will reimburse OPD expenses maximum up to Rs. 5,000 in a block of every three years for treating Dental and/or Ophthalmic pathology/diseases excluding any form of cosmetic treatments and treatments payable with respect of:

i. Out-patient consultations by a medical practitioner.
ii. Diagnostic tests prescribed by a medical practitioner.
iii. Medicines/drugs prescribed by a medical practitioner.

ADDITIONAL SUM INSURED FOR CRITICAL ILLNESS: If an insured person suffers from any critical illness as defined by the IRDAI during the policy period and the selected basic sum insured is exhausted in the treatment of that critical illness, then additional sum insured of 10% of base sum insured shall be available , only for treatment of the critical illness, provided that Diagnosis of the critical illness is supported by the clinical, radiological, histological and laboratory evidence acceptable to the company.

Critical Illness includes the following illness/ surgeries

1. Cancer of specified severity
2. Myocardial infarction (first heart attack)
3. Open chest CABG
4. Open heart replacement or repair of heart valves
5. Coma of specified severity
6. Kidney failure requiring regular dialysis
7. Stroke resulting in permanent symptoms
8. Major organs/ bone marrow transplant
9. Permanent paralysis of limbs
10. Motor neuron disease with permanent symptoms
11. Multiple Sclerosis with Persisting Symptoms
12. Angioplasty
13. Benign brain tumour.
14. Blindness
15. Deafness
16. End stage lung failure
17. End stage liver failure
18. Loss of speech
19. Loss of Limbs
20. Major Head trauma
21. Primary (idiopathic) pulmonary hypertension
22. Third degree burns.

TELEMEDICINE-Expenses incurred by insured on telemedicine/Tele-consultation with a registered medical practitioner for Diagnosis & treatment of a disease/illness covered under the Policy. Such reasonable incurred expenses will be reimbursable wherever consultation with a registered medical practitioner is allowed in the terms and conditions of policy contract and shall be subject to Limits/Sublimit prescribed in Policy Schedule. Telemedicine offered shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020 by MCI and as amended from time to time. "The limit of amount payable for telemedicine is maximum Rs. 2,000/- per person, for a policy period.

HIV/ AIDS COVER: The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-Patient Care, Pre and Post Hospitalization Expenses related to HIV infection.

MENTAL ILLNESS COVER The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) only under certain conditions as:-

1. Illness covered under definition of mental illness mentioned under clause 3.52.
2. Hospitalization in Mental Health Establishment as defined under clause 3.53.
3. Hospitalization as advised by Mental Health Professional as defined under clause 3.54.
4. Mental Conditions associated with the abuse of alcohol and drugs are excluded.
5. Mental Retardation and associated complications arising therein are excluded.
6. Any kind of Psychological counseling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalization is not necessary shall not be covered.

4.1.6 PERSONAL ACCIDENT COVER: (WORLD - WIDE) If at any time during the currency of the policy, the insured sustains any bodily injury, resulting solely and directly from sudden, unforeseen and involuntary event caused by external, visible and violent means anywhere in the world, and if such injury, within 12 months of its occurrence be the sole and direct cause of death or disability, as covered under the policy, then the Company undertakes to pay to the insured or his nominee or in the absence of nominee, the legal heir, as the case may be, the following sums :

Sl.No.	Benefits covered	Amount payable
1	Accidental Death only	100 % of CSI
2	Loss of two entire limbs, or sight of two eyes or one entire limb and sight of one eye	100 % of CSI
3	Loss of one entire limb or Sight of one eye	50 % of CSI
4	Permanent Total Disablement resulting in totally and absolutely disabling the person insured from engaging in any employment or occupation whatsoever.	100 % of CSI

The overall liability in the event of one or more of the eventualities (listed above) occurring shall be restricted to the CSI. CSI means Capital Sum Insured opted under the Personal Accident section and mentioned in the schedule.

EXCLUSIONS: The Company shall not be liable under this section for disablement / death of the Insured Person

i. on account of Intentional self-injury, suicide or attempted suicide
ii. Whilst under the influence of intoxicating liquor
iii. Whilst engaging in any hazardous activity including, but not limited to aviation or ballooning, speed contests or racing of any kind(other than on foot), bungee jumping, parasailing, parachuting, ski-diving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world.
iv. Caused by insanity.
v. Arising or resulting from insured committing breach of law with criminal intent
vi. War, invasion, act of foreign enemy, hostilities(whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainments of people

vii. Caused by or arising from ionizing radiations or contamination By radioactivity from any nuclear fuel, nuclear weapon material, or from any nuclear waste from the combustion of nuclear fuel,

viii. Caused by, contributed to, aggravated or prolonged by childbirth or from pregnancy or in Consequence thereof.

4.1.7 ADVANCED TREATMENTS All the following procedures, will be covered in the policy, if treated as in-patient care or as a part of domiciliary hospitalization or as day care treatment in the hospital, within the sub-limits in the complete policy period which is as defined below:

Name of the Procedure	**Sub limits for sum insured slab from Rs.1.0 lac to Rs. 10.0 lacs**	**Sub limits for sum insured slab from Rs.12.0 lac to Rs. 50.0 lacs**
A. Uterine Artery Embolization and HIFU	Per policy period: Up to INR 50,000.	
B. Balloon Sinuplasty	Per policy period: Up to INR 40,000.	
C. Deep Brain stimulation	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
D. Oral chemotherapy	Per policy period 25% of SI, subject to maximum INR 50,000.	Per policy period: Up to INR 1,50,000.
E. Immunotherapy-Monoclonal Antibody to be given as injection	Per policy period 50% of SI, subject to maximum INR 2,50,000.	Per policy period 50% of SI, subject to maximum INR 10,00,000.
F. Intra vitreal injections	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
G. Robotic surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.*	Per policy period 10% of SI, subject to maximum INR 2,00,000.*
	***(The sub limit is on the cost incurred due to modern treatment methods of robotics and associated expenses and this amount is over and above the limit for conventional surgery for that ailment).**	
H. Stereotactic radio surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.	Per policy period 10% of SI, subject to maximum INR 2,00,000.
I. Bronchial Thermoplasty	Per policy period 10% of SI, subject to maximum INR 1,00,000.	Per policy period 10% of SI, subject to maximum INR 2,00,000.
J. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
K. IONM - (Intra Operative Neuro Monitoring)	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.

conditions to be covered.		

5. **EXCLUSIONS:** The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

STANDARD EXCLUSIONS

5.1 Pre-existing Diseases - code -ExcI0 1

A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with the insurer.

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

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

D. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

5.2 Specified disease / procedure waiting period- code- ExcI02

A. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of the specified waiting period of the continuous coverage after the date of inception of the first policy with us. In case of enhancement of sum insured this exclusion shall apply afresh to the extent of sum insured increase.

B. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

F. The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first Policy (subject to continuity being maintained), are not payable during the waiting period specified below.

	Ailment / Disease / Surgery	**Waiting Period**
I	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
Ii	Polycystic ovarian diseases.	1 year
Iii	Surgery of hernia.	2 years

Iv	Surgery of hydrocele.	2 years
V	Non infective Arthritis.	2 years
Vi	Undescendent Testes.	2 Years
Vii	Cataract.	2 Years
Viii	Surgery of benign prostatic hypertrophy.	2 Years
Ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus	2 Years
X	Fissure / Fistula in anus.	2 Years
Xi	Piles.	2 Years
Xii	Sinusitis and related disorders.	2 Years
Xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
Xiv	Surgery ofgenito-urinary system excluding malignancy.	2 Years
Xv	Pilonidal Sinus.	2 Years
Xvi	Gout and Rheumatism.	2 Years
Xvii	Hypertension.	90 days
Xviii	Diabetes.	90 days
Xix	Calculus diseases.	2 Years
Xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
Xxi	Surgery of varicose veins and varicose ulcers.	2 Years
Xxii	Congenital internal diseases.	2 Years
Xxiii	Joint Replacement due to Degenerative condition.	4 Years
Xxiv	Age related osteoarthritis and Osteoporosis.	4 Years

5.3 30 day waiting period- code – ExcI03

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

b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

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

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 5.1., 5.2, 5.3 shall apply afresh, unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorized official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first Policy, clauses 5.1, 5.2 and 5.3 shall apply afresh on the enhanced portion of the Sum Insured.

5.4 Investigation & Evaluation – Code – ExcI04

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

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

5.5 Rest Cure, rehabilitation and respite care – Code -ExcI05

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- Custodial care either at home or in a nursing facility for personal care such as help with

activities of daily living such a bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

5.6 **Obesity/Weight Control : Code- ExcI06** Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor.

b. The surgery /Procedure conducted should be supported by clinical protocols.

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI):

- greater than or equal to 40 or
- greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failures of less invasive methods of weight loss:

i. Obesity – related cardiomyopathy

ii. Coronary heart diseases

iii. Severe Sleep Apnea.

iv. Uncontrolled Type 2 Diabetes.

5.7 **Change of Gender Treatments: Code – ExcI07** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

5.8 Cosmetic or Plastic Surgery- Code- ExcI08 Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident burns(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical practitioner.

5.9 **Hazardous or Adventure sports- Code- ExcI09** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

5.10 **Breach of law – Code –ExcI10** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

5.11 **Excluded Providers- Code – ExcI11** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policy holders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not complete claim.

5.12 **Treatment for, Alcoholic drug or substance abuse** or any addictive condition and consequences thereof.– Code- ExcI12

5.13 Treatments received in health hydro's, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- **Code- ExcI13**

5.14 Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.- **Code- ExcI14**

5.15 **Refractive Error- Code- ExcI15**

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

5.16 Unproven Treatments- Code – ExcI16

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

5.17 Sterility and Infertility- Code- ExcI17 Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization.

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI. This exclusion does not apply to platinum plan up to the limits mentioned therein.

iii. Gestation Surrogacy

iv. Reversal of sterilization.

5.18 Maternity- Code- ExcI18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization) except ectopic pregnancy.

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SPECIFIC EXCLUSIONS:-

5.19 Hormone Replacement Therapy Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders

5.20 General Debility, Congenital External Anomaly General debility, congenital external anomaly.

5.21 Self Inflicted Injury Treatment for intentional self-inflicted injury, attempted suicide.

5.22 Stem Cell Surgery Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for hematological conditions).

5.23 Circumcision unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.

5.24 Vaccination or Inoculation. Vaccination or inoculation unless forming part of treatment and requires Hospitalization, except as and to the extent provided for under Section 3.1 (Anti Rabies Vaccination).

5.25 Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy) Massages, steam bath, expenses for alternative or AYUSH treatments (other than Ayurveda and Homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

5.26 Dental treatment Dental treatment, unless necessitated due to an Injury.

5.27 Out Patient Department (OPD) Any expenses incurred on OPD.

5.28 Stay in Hospital which is not Medically Necessary. Stay in hospital which is not medically necessary.

5.29 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants Spectacles, contact lens, hearing aid, cochlear implants.

5.30 Non Prescription Drug Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in respective Appendix-II).

5.31 Treatment not related to Disease for which Claim is Made Treatment which the insured person was on before Hospitalization for the Illness/Injury, different from the one for which claim for Hospitalization has been made.

5.32 Equipment's External/durable medical/non-medical equipment's/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in respective Appendix-II) and any medical equipment which could be used at home subsequently.

5.33 Items of personal comfort Items of personal comfort and convenience (as listed in respective Appendix-II) including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

5.34 Service charge/ registration fee Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in respective Appendix-II) levied by the hospital.

5.35 Home visit charges Home visit charges during Pre and Post Hospitalization of doctor, attendant and nurse.

5.36 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

5.37 Radioactivity Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

5.38 Treatment taken outside the geographical limits of India.

5.39 Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

5.39 Permanently Excluded Diseases In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on the insured's consent), policyholder is not entitled to get the coverage for specified ICD coded as listed below:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill- defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy

4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083

10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

6. TERMS & CLAUSES

STANDARD GENERAL TERMS & CLAUSES

6.1 **DISCLOSURE OF INFORMATION:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6.2 **CONDITION PRECEDENT TO ADMISSION OF LIABILITY:** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

CLAIM SETTLEMENT (provision for Penal Interest):

- The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to

the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

- However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above bank rate from the date of receipt of last necessary document to the date of payment of claim. ("Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

6.3 **COMPLETE DISCHARGE:** Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall be a valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6.4 **FRAUD:** If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited. Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

i. the suggestion as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis- statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6.5 **CANCELLATION CLAUSE**: The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period on Risk	Rate of premium to be charged
Up to 1 Month	1/4th of the annual rate
Up to 3 Months	1/2 of the annual rate
Up to 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy. The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of material facts fraud by the insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation non- disclosure.

6.6 **MIGRATION:** The insured person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link:-
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

6.7 **FREE LOOK PERIOD:** The free look period shall be applicable on new individual health insurance Policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of 15 days from the date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable. If the Insured has not made any claim during the free look period, the Insured shall be entitled to

- A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Persons and the stamp duty charges or
- where the risk has already commenced and the option of return of the Policy is exercised by the Insured person, a deduction towards the proportionate risk premium for period on cover or
- Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

6.8 **RENEWAL OF POLICY:** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

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

6.9 PORTABILITY: The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

6.10 WITHDRAWAL OF POLICY

- In the likelihood of this product being withdrawn in future, the Company will intimate the Insured person about the same 90 days prior to expiry of the policy.
- Insured person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits if any such as waiver of waiting period etc. As per IRDAI guidelines, provided the policy has been maintained without a break.

6.11 MORATORIUM PERIOD After completion of eight continuous years under this policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

6.12 POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES: The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

6.13 GRIEVANCE REDRESSAL In case of any grievance the insured person may contact the company through

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.If insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at: Customer Service Department 4th Floor, Agarwal House Asaf Ali Road,New Delhi-110002. For updated details of grievance officer, kindly refer the link
https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac- c613-ffc05d578a3e

6.14 **INSURANCE OMBUDSMAN** –If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure- III & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html.

6.15 **NOMINATION:** The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only

when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

SPECIFIC TERMS & CLAUSES:-

6.16 **ENTIRE CONTRACT:** This Policy /Prospectus/ Proposal Form and declaration given by the insured constitute the complete contract. Insurer may alter the terms and conditions of this Policy/contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the Policy.

6.17 **COMMUNICATION:** Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the Policy issuing office / Third Party Administrator as shown in the Schedule.

6.18 **PAYMENT OF PREMIUM:** The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

6.19 **PREMIUM PAYMENT IN INSTALLMENTS:** If the insured person has opted for payment of Premium on an Half Yearly installment basis the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

I. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
II. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
III. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
IV. No interest will be charged If the installment premium is not paid on due date.
V. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

6.20 **NOTIFICATION OF CLAIM**: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of Insured Person in respect of whom claim is made, Nature of disease / Injury and Name and Address of the attending Medical Practitioner / Hospital /Nursing Home etc. should be given to the Company/ TPA while taking treatment in the Hospital / Nursing Home by fax, e-mail. Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, unless waived in writing.

6.21 **CLAIM DOCUMENTS:** Final claim along with original Bills/ Cash memos/reports, claim form and documents as listed below should be submitted to the Company / TPA within 15 days of discharge

from the Hospital / Nursing Home.

- Original bills, all receipts and discharge certificate / card from the Hospital.
- All documents pertaining to the Illness, starting from the date it was first detected, i.e. Doctor's consultations reports/history
- Medical history of the patient recorded by the Hospital.
- Original Cash-memo from the Hospital (s) / chemist (s) supported by proper prescription.
- Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending Medical Practitioner / Surgeon demanding such tests.
- Original attending Consultants / Anesthetists/ Specialist certificates regarding diagnosis and bills / receipts etc.
- Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
- MLC/FIR/Post Mortem Report,(if applicable)
- Disability certificate, Death certificate (if applicable)
- Documents in respect of organ donation claim, shall be in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs
- Details of previous policies, if the details are already not with TPA.
- Any other information required by TPA /Company.

a. All documents must be duly attested by the Insured Person/Claimant.
b. In case of Post Hospitalization treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. in addition insured should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.
c. Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.
d. On receipt of the last document /clarification, the Company/TPA shall within a period of 30 days offer a settlement of the claim to the insured. If the Company/TPA, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of the last document/ clarification.

6.22 **PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME:**

- Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital/ Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the Policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted

as an in-patient. The Company / TPA reserves the right to deny pre-authorization in case the Hospital / Insured Person is unable to provide the relevant information/medical details as required by the Company/ TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability. The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of the discharge from Hospital / Nursing Home for consideration of Company /TPA.

- Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorization of cashless facility may be withdrawn? However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect given to the treating Hospital / insured.
- List of network Hospitals is available on our official website- www.orientalinsurance.org.in and will also be provided by the concerned TPA on demand.

6.23 **MEDICALRECORDS:**

- The Insured Person hereby agrees to and authorizes the disclosure, to the Company/ TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this Policy or the Company's liability there under.
- The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this Policy or the Company's liability there under.
- Any Medical Practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged Injury or disease requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company/ TPA.

6.24 **PAYMENT OF CLAIM:** All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only. Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In the cases of any delay in the payment, the Company shall be liable to 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.

6.25 CONTRIBUTION: If the Insured Person is covered under more than one Policy issued by the Company or by any other Insurer, where such policies indemnify treatment cost, the Insured Person shall have the right to require a settlement of his claim in terms of any of his policies, provided the admissible claim is within the limits of and according to the terms of the chosen Policy. If the amount to be claimed exceeds the Sum Insured under a single Policy after considering Deductibles or Co- payments, the Insured Person shall have the right to choose Insurer by whom the claim is to be settled. In such cases the Company shall not be liable to pay or contribute more than its rate able proportion of the admissible claim. The Insured Person is duty bound to disclose such other insurance at the time of making a claim under this Policy.

6.26 **CLAIM FALLING IN TWO POLICY PERIODS:** If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period. 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 premium of Health Insurance Policy, if not received earlier.

6.27 **REPUDIATION:**

- The Company, shall repudiate the claim if not payable under the Policy. The Company/ TPA shall mention the reasons for repudiation in writing to the Insured Person. The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A- 25/27, Asaf Ali Road, NewDelhi-110002.
- If the insured is not satisfied with the reply of the Customer Service department under 5.13, he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims uptoRs.30lacs.

6.28 **DISCLAIMER OF CLAIM:** If the Company shall disclaim liability and communicate in writing (either through the TPA or by itself) to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable here under.

6.29 **ARBITRATIONCLAUSE:** If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties; or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act,1996.It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

OTHER TERMS & CONDITIONS

6.30 SUM INSURED: Minimum sum insured is Rs 100,000 and in multiples of Rs 50,000 up to Rs5, 00,000. Beyond the Sum Insured of Rs. 5,00,000 in multiples of Rs. 1,00,000 Up to Rs 10,00,000. Thereafter the sum insured slabs available are Rs. 12, 15, 18, 20, 25, 30, 40 and 50 lakhs. The sum insured of each of the insured person in a policy may vary. Maximum sum insured that can be opted by a person joining after the age of 65 years is Rs.5 lakhs.

6.31 **ENHANCEMENT OF SUMINSURED:** The insured may seek enhancement of Sum Insured in writing before payment of premium for renewal. Before granting such request for enhancement of Sum Insured, if deemed necessary by the Underwriting Authority. The Company has the right to have the insured examined by a Medical Practitioner authorized by the Company or the TPA. The cost of such medical examination will be borne by the insured/s.The consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner.

Enhancement of Sum Insured shall be allowed based on the following table:

Age<=45 years	Enhancement up to maximum Sum Insured available without Medical Examination.
Age 46-60 Years	Enhancement by two slabs without Medical Examination.
Age 61-65 Years	Enhancement by one slab without Medical Examination.
Age above 65 Years	Enhancement by one slab with Medical Examination.

For those Insured Person/s who had undergone Hospitalization in the preceding two years, sum insured enhancement up to one step higher from the current Sum Insured only to be allowed. In respect of any increase in Sum Insured, exclusion 5.1, 5.2 and 5.3 would apply to the additional Sum Insured from the date of such increase.

6.32 **MIDTERM INCLUSION:** Midterm inclusion of members is permitted under the Policy, on payment of pro-rata premium only for

- Newly wed spouse within 90 days of marriage or at the time of renewal of the Policy.
- Newborn child from 91 day of birth or at the time of renewal of the Policy.

For members subsequently added, Exclusion No. 5.1, 5.2 and 5.3 shall apply from the date of their inclusion in the Policy

6.33 **PROPORTIONATE CLAUSE** - If the Insured Person is admitted in the hospital in a room where the room category or the Room Rent incurred is higher than the eligibility as specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a ratable proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred. However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics.

6.34 PREMIUM LOADING / DISCOUNTS

(a) MAXIMUM ENTRY AGE: Maximum Entry age for any member, is 65years.

(b) ENTRY LOAD: Maximum entry age (65years) under the policy can be extended upto 70 years. In all such cases, a 10% loading will be charged on premium applicable to the age of the insured. This 10% loading will also apply on each subsequent renewal thereof. The loading shall also apply on PA cover, if opted for.

(c) FAMILY DISCOUNT: of 10% (including on Optional PA cover) if more than one person is covered under the policy.

(d) VOLUNTARY CO-PAYMENT DISCOUNT: If the insured opts for a Co-payment of 10% or 20% (each and every claim), he is eligible for a corresponding premium discount of 10% and 20% respectively.
(e) ON-LINE DISCOUINT: A discount of 10% (maximum Rs. 2000/-) on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.
(f) Discount of 5.5% in premium if TPA services not opted for.

6.35 **COST OF HEALTH CHECK UP:** The Insured shall be entitled for reimbursement of cost of Health checkup undertaken once at the expiry of a block of every THREE continuous underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average sum Insured (SI for PA section is not to be considered), or Rs.5000/- per insured person, whichever is less, during the block of THREE claim free underwriting years. This benefit is available to the insured person after three claim free years, till the expiry of the fourth year of the policy. If the benefit is not claimed in the fourth year of the policy, then in future at the time of the insured claiming this benefit, last three claim free years preceding the year in which the benefit is claimed, shall be taken into consideration. This clause shall apply separately to each insured person i.e for any insured person, if there is no claim reported for the preceding three years, he would be eligible for this benefit even when there is a claim reported for other person(s) covered under the policy. This provision is applicable only in respect of continuous insurance without break under Oriental's Mediclaim Insurance Policy (individual).

6.36 **MULTIPLE POLICIES**

- In case of multiple policies taken by an insured person during a period from the same or one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
- If the amount to be claimed exceeds the sum insured under a single policy after, the insured person shall have the right to choose insurers from whom he/she wants to claim theBalance amount.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

6.37 **ASSOCIATED MEDICAL EXPENSES:**

- Doctor's fees / Consultant fees/RMO fees
- Nursing expenses including administration charges/ transfusion charges/ injection charges
- Surgeon fees / Asst Surgeon fees
- Anesthesia fees
- Procedure charges of any kind which includes :-
- Chemotherapy/Radiotherapy charges Nebulization

- Hemodialysis PICC
- line insertion
- Catheterization charges Tracheostomy etc.
- IV charges
- Blood transfusion charges
- Dialysis
- Surgery Charges
- OT charges including OT gas, equipment charges.

6.38 **GRACE PERIOD:** In the event of delay in renewal of the Policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

6.39 **CHANGE OF ADDRESS:** Insured must inform the Company immediately in writing of any change in the address.

6.40 **QUALITY OF TREATMENT:** The insured hereby acknowledges and agrees that pre-authorization or payment of any claim by or on behalf of the Company shall not constitute on part of the Company, a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the Insured Person. It being agreed and recognized by the Insured Person that the Company is in no way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a Network Hospital).

6.41 **ID CARD:** The card is issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital only. Upon the cancellation or nonrenewal of this Policy, all ID cards shall immediately be returned to the TPA at the insured's expense and each Insured Person agrees to hold and keep harmless, the Company and the TPA against any or all costs, expenses, liabilities and claims arising in respect of use or misuse of such ID cards prior to their return to the TPA.

6.42 **DISCOUNT ON OMP PREMIUM:** In case an insured person covered under this policy goes abroad by taking Oriental's Overseas Mediclaim Policy (OMP), this Policy becomes inoperative for the period the OMP is in force while he / she is abroad. The proportionate premium under this policy for the inoperative period shall be adjusted against the renewal premium of the said insured person. The insured person must inform the company in writing before leaving India stating the details of visit(s) abroad and the OMP policy.

6.43 **SUBROGATION:** In the event of a claim paid under the policy, the Company shall assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

6.44 **IRDAI REGULATION:** This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017andIRDAI (Health Insurance) Regulations2016and Guidelines on Standardization in health insurance, as amended from time to time.

6.45 **JURISDICTION:** All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and in accordance with the Indian Laws.

6.46 HOW TO APPLY FOR INSURANCE: The Proposer has to complete the Proposal Form and Enrolment Form in duplicate and submit Insured Person's details of each member. The proposer has to affix colored stamp size photographs of each of the members to be insured on the Enrolment Form against the name of the person. These photographs will be utilized by Third Party Administrator for preparing ID card for each of the members insured.

The Prospectus contains salient features of the Policy. For details, reference is to be made to the Policy. In case of any difference between the Prospectus and the Policy, the terms and conditions of the Policy shall prevail. The Prospectus and Proposal Form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal Form is to be completed in all respects for each insured Person. Both the Prospectus and the Proposal Form are to be submitted to the office or to the agent.

Name: Signature

Address:

Place: Date:

Note: For legal interpretation only English version will be valid.

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

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

PREMIUM SCHEDULE - ORIENTAL MEDICLAIM INSURANCE POLICY (INDIVIDUAL)

Office Premium per Insured (INR)(Excluding GST) (Yearly)								
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is 61-70 yrs**	**Age is 71-80 yrs**	**Age is above 80 yrs**
100,000	1,861	2,933	3,445	4,628	7,281	10,313	13,222	15,013
150,000	2,294	3,636	4,332	6,523	8,962	13,075	16,622	19,480
200,000	2,791	4,404	5,157	8,001	10,697	15,720	19,841	23,145
250,000	3,112	4,888	5,767	9,286	12,210	18,119	22,816	26,230
300,000	3,407	5,274	6,359	10,565	13,645	20,533	25,635	29,471
350,000	3,756	5,710	7,073	11,925	15,185	22,384	27,932	32,113
400,000	3,970	5,978	7,549	13,087	16,401	23,787	29,559	33,986
450,000	4,226	6,240	8,077	13,695	17,601	25,171	31,069	35,721
500,000	4,457	6,450	8,582	14,266	18,661	26,472	32,566	37,442
600,000	4,609	6,953	9,599	16,174	22,274	32,858	39,640	45,577
700,000	4,987	7,661	10,707	17,757	25,046	36,923	44,675	51,369
800,000	5,333	8,349	11,760	19,247	27,318	40,354	48,302	55,541
900,000	5,666	8,882	12,785	20,694	29,333	43,296	51,117	58,777
1,000,000	5,991	9,352	13,812	22,051	31,326	46,107	53,726	61,776
1,200,000	7,202	10,932	16,480	25,328	36,352	52,627	59,855	68,749
1,500,000	8,078	12,403	19,066	28,526	41,268	58,973	65,620	75,376
1,800,000	8,937	13,839	21,397	31,534	45,337	64,053	70,163	80,600
2,000,000	9,456	14,778	22,716	33,444	47,749	67,025	72,806	83,637
2,500,000	12,849	18,716	27,504	39,565	55,264	75,833	81,183	92,962
3,000,000	13,864	19,886	29,189	41,673	58,845	80,075	85,031	97,481
4,000,000	14,787	21,193	31,279	44,512	63,275	85,444	89,956	103,833
5,000,000	15,357	22,057	32,991	46,566	66,184	88,853	93,101	107,943

Office Premium per Insured (INR)(Including GST) (Yearly)								
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is 61-70 yrs**	**Age is 71-80 yrs**	**Age is above 80 yrs**
100000	2196	3461	4065	5461	8592	12169	15602	17715
150000	2707	4290	5112	7697	10575	15429	19614	22986
200000	3293	5197	6085	9441	12622	18550	23412	27311
250000	3672	5768	6805	10957	14408	21380	26923	30951
300000	4020	6223	7504	12467	16101	24229	30249	34776

350000	4432	6738	8346	14072	17918	26413	32960	37893
400000	4685	7054	8908	15443	19353	28069	34880	40103
450000	4987	7363	9531	16160	20769	29702	36661	42151
500000	5259	7611	10127	16834	22020	31237	38428	44182
600000	5439	8205	11327	19085	26283	38772	46775	53781
700000	5885	9040	12634	20953	29554	43569	52717	60615
800000	6293	9852	13877	22711	32235	47618	56996	65538
900000	6686	10481	15086	24419	34613	51089	60318	69357
1000000	7069	11035	16298	26020	36965	54406	63397	72896
1200000	8498	12900	19446	29887	42895	62100	70629	81124
1500000	9532	14636	22498	33661	48696	69588	77432	88944
1800000	10546	16330	25248	37210	53498	75583	82792	95108
2000000	11158	17438	26805	39464	56344	79090	85911	98692
2500000	15162	22085	32455	46687	65212	89483	95796	109695
3000000	16360	23465	34443	49174	69437	94489	100337	115028
4000000	17449	25008	36909	52524	74665	100824	106148	122523
5000000	18121	26027	38929	54948	78097	104847	109859	127373

Office Premium per Insured (INR)(Excluding GST) (Half Yearly)								
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is 61-70 yrs**	**Age is 71-80 yrs**	**Age is above 80 yrs**
100,000	968	1,526	1,792	2,407	3,787	5,364	6,877	7,808
150,000	1,193	1,891	2,253	3,393	4,661	6,800	8,645	10,131
200,000	1,452	2,291	2,682	4,162	5,564	8,176	10,319	12,038
250,000	1,618	2,542	2,999	4,829	6,350	9,424	11,866	13,642
300,000	1,772	2,743	3,308	5,495	7,097	10,679	13,333	15,328
350,000	1,953	2,970	3,678	6,202	7,897	11,642	14,527	16,702
400,000	2,065	3,109	3,926	6,807	8,530	12,372	15,374	17,676
450,000	2,198	3,245	4,201	7,123	9,154	13,091	16,159	18,579
500,000	2,318	3,355	4,463	7,419	9,705	13,768	16,937	19,474
600,000	2,397	3,616	4,993	8,412	11,584	17,089	20,616	23,704
700,000	2,594	3,985	5,569	9,235	13,026	19,204	23,235	26,717
800,000	2,773	4,342	6,116	10,010	14,208	20,988	25,122	28,887
900,000	2,947	4,620	6,649	10,763	15,256	22,518	26,586	30,570
1,000,000	3,116	4,864	7,184	11,469	16,292	23,980	27,942	32,130
1,200,000	3,746	5,686	8,571	13,173	18,906	27,371	31,131	35,756
1,500,000	4,201	6,451	9,916	14,836	21,463	30,672	34,129	39,203
1,800,000	4,648	7,198	11,128	16,401	23,579	33,314	36,492	41,920

2,000,000	4,918	7,686	11,815	17,394	24,834	34,860	37,866	43,500
2,500,000	6,683	9,734	14,305	20,578	28,742	39,440	42,223	48,349
3,000,000	7,211	10,343	15,181	21,674	30,605	41,646	44,224	50,700
4,000,000	7,691	11,022	16,268	23,150	32,909	44,439	46,786	54,003
5,000,000	7,987	11,472	17,159	24,219	34,422	46,212	48,422	56,141

Office Premium per Insured (INR)(Including GST)								
(Half Yearly)								
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is 61-70 yrs**	**Age is 71-80 yrs**	**Age is above 80 yrs**
100000	1142	1801	2115	2840	4469	6330	8115	9213
150000	1408	2231	2659	4004	5500	8024	10201	11955
200000	1713	2703	3165	4911	6566	9648	12176	14205
250000	1909	3000	3539	5698	7493	11120	14002	16098
300000	2091	3237	3903	6484	8374	12601	15733	18087
350000	2305	3505	4340	7318	9318	13738	17142	19708
400000	2437	3669	4633	8032	10065	14599	18141	20858
450000	2594	3829	4957	8405	10802	15447	19068	21923
500000	2735	3959	5266	8754	11452	16246	19986	22979
600000	2828	4267	5892	9926	13669	20165	24327	27971
700000	3061	4702	6571	10897	15371	22661	27417	31526
800000	3272	5124	7217	11812	16765	24766	29644	34087
900000	3477	5452	7846	12700	18002	26571	31371	36073
1000000	3677	5740	8477	13533	19225	28296	32972	37913
1200000	4420	6709	10114	15544	22309	32298	36735	42192
1500000	4957	7612	11701	17506	25326	36193	40272	46260
1800000	5485	8494	13131	19353	27823	39311	43061	49466
2000000	5803	9069	13942	20525	29304	41135	44682	51330
2500000	7886	11486	16880	24282	33916	46539	49823	57052
3000000	8509	12205	17914	25575	36114	49142	52184	59826
4000000	9075	13006	19196	27317	38833	52438	55207	63724
5000000	9425	13537	20248	28578	40618	54530	57138	66246

These Office Premium rates are applicable for insureds taking cover on individual basis. For calculation of Office Premium for multiple insureds taking cover under single policy, each with their own SI, Family Discount of 10% shall be applicable on the Office Premium rates derived from the Office Premium rate chart.

Pricing of Optional Covers:

Personal Accident:

- The Coverage and premium rate for this optional cover has been kept identical as per existing product.
- SI available: in multiples of INR 2 lakhs up to INR 10 lakhs, per insured.

Personal Accident Premium Table:

Sum Insured (in INR)	Premium per person (INR)(Yearly)
200,000	120
400,000	240
600,000	360
800,000	480
1,000,000	600

As regards half-yearly premium for the PA optional cover, it has been calculated along similar lines to the base product, and the premium works out to:

Sum Insured (in INR)	Premium per person (INR)(Half- Yearly)
200,000	62
400,000	125
600,000	187
800,000	250
1,000,000	312

Discount/Loading Factors:

(a) MAXIMUM ENTRY AGE: Maximum Entry age for any member, is 65years.
(b) ENTRY LOAD: Maximum entry age (65years) under the policy can be extended upto 70 years. In all such cases, a 10% loading will be charged on premium applicable to the age of the insured. This 10% loading will also apply on each subsequent renewal thereof. The loading shall also apply on PA cover, if opted for.
(c) FAMILY DISCOUNT: of 10% (including on Optional PA cover) if more than one person is covered under the policy.
(d) VOLUNTARY CO-PAYMENT DISCOUNT: If the insured opts for a Co-payment of 10% or 20% (each and every claim), he is eligible for a corresponding premium discount of 10% and 20% respectively.
(e) ON-LINE DISCOUINT: A discount of 10% (maximum Rs. 2000/-) on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.
(f) Discount of 5.5% in premium if TPA services not opted for.