THE ORIENTAL INSURANCE COMPANY LIMITED

Regd.Office:Oriental House,P.B.No.7037,A-25/27,Asaf Ali Road, New Delhi-110 002

CIN No. U66010DL1947GOI007158

ORIENTAL INSURANCE BANK SAATHI POLICY-GROUP

POLICY DOCUMENT

1. WHEREAS the insured named in the Schedule hereto has by a proposal and declaration (which shall be the basis of this Contract and is deemed to be incorporated herein) has applied to **THE ORIENTAL INSURANCE COMPANY LIMITED** (hereinafter called the Company) for the insurance hereinafter set forth in respect of person(s) (including their eligible Family Members) named in the schedule hereto (herein after called the Insured Person) and has paid premium as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the TPA) or the Company as the case maybe. The Insured Person is eligible to be covered under this policy from birth/90 days (as a dependent child) up to the age of 79 years with lifelong renewability subject to continuous renewal of the group policy.

NOW THIS POLICY WITNESSES that subject to the terms, Conditions, exclusions and definitions contained herein or endorsed or otherwise expressed here on the Company undertakes that if during the period stated in the schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any illness (herein after called DISEASE) or sustain any bodily injury through accident (herein after called INJURY) and if such disease or injury shall require any such Insured Person, upon the medical advice of a duly qualified Physician/ Medical Specialist/ Medical Practitioner (herein after called MEDICAL PRACTITIONER) or of a duly qualified surgeon (herein after called SURGEON) to incur Inpatient care/ Emergency care/ Domiciliary Hospitalisation expenses for medical/ surgical treatment at any Nursing Home/ Hospital in India as herein defined (herein after called HOSPITAL) as an inpatient, the Company will pay to the Insured Person the amount of such expenses as would fall under different heads mentioned below, and as are medically necessary and reasonable & customary charges incurred therefore by or on behalf of such Insured Person, but not exceeding the sum insured for the person in any one period of such insurance as mentioned in the schedule hereto.

2 COVERAGE AND ELIGIBILITY:

2.1 The Policy covers reasonable and customary charges/expenses incurred in respect of Hospitalization and /or Domiciliary Hospitalisation for medically necessary **treatment** only for Illnesses / diseases contracted / suffered or Injury sustained by the Insured Person(s) during the Policy Period, upto the limit of Sum Insured or specific sub limits , as detailed below:

SR. NO.	**INSURED COVERAGE**	**LIMIT OF INDEMNITY**	
	IN PATIENT HOSPITALISATION EXPENSES		
I	Sum Insured (INR)	**PLAN A**	**PLAN B**
		2, 3, 4 & 5	**6, 8, 10, 15, 20, & 25**
II	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home including nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges.	1% of the Sum Insured per day	1% of the Sum Insured per day for 6, 8, 10 Lacs. For SI levels above 10 Lacs, 1% of 10 lac plus 0.5% of every additional 1 lac of SI above 10 lacs.
III	Intensive Care Unit (ICU) or Specialised Expenses as provided by the Hospital /Nursing Home.	2% of the Sum Insured per day	2% of the Sum Insured per day for 6, 8, 10 lacs. For SI levels above 10 Lacs, 1% of every additional 1 Lac of SI above 10 Lacs.
IV	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees ** Detailed terms & conditions as per Clause 2.2	As per the limits of Sum Insured subject to "a" and "b" below and Proportionate Clause	
V	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Prosthetic devices implanted during Surgery, Relevant Laboratory / Diagnostic tests, X-Ray and other medical expenses related to the covered treatment	As per the limits of Sum Insured subject to "a" and "b" below and Proportionate Clause ** Detailed terms & conditions as per Clause 2.2	

a. Number of days of stay under 'ii' and 'iii' above should not exceed total number of days of admission in the Hospital. All related expenses (including iv & V 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 3.48, or, in excess of the negotiated prices (in case of network hospitals) shall be borne by the insured.		
VI	Road Ambulance Cover ** Detailed terms & conditions as per Clause 2.3	□ Per Illness - Rs.1000 maximum. □ Per policy period 1% of Sum Insured, Subject to maximum of Rs.3000.	□ Per Illness - Rs.2000 maximum. □ Per policy period 1% of Sum Insured, Subject to maximum of Rs.10000.
VII	Organ Donor Expenses – When Insured Person is Recipient ** Detailed terms & conditions as per Clause 2.4	Upto Sum Insured of the Insured Person receiving the organ.	
VIII	Pre and Post Hospitalisation expenses ** Detailed terms & conditions as per Clause 2.5 & 2.6	Medical expenses incurred 30 days prior to hospitalisation and upto 60 days post hospitalisation.	
IX	AYUSH Treatment Expenses ** Detailed terms & conditions as per Clause 2.7	Upto 25 % of Sum Insured for treatment as In Patient	
X	Mental Illness Cover	** Detailed terms & conditions as per Clause 2.8	
XI	Patient's Attendant Allowance ** Detailed terms & conditions as per Clause 2.9	Not Available	Rs500/- per day of Hospitalization, subject to maximum compensation for 10 days per illness. Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalization.
XII	Coverage for Modern Treatment &	As per sub Limits mentioned in Clause 2.10	

	Techniques/Method		
XIII	Telemedicine/Teleconsultation ** Detailed terms & conditions as per Clause 2.11	INR 2000/- per family, for a policy period.	
XIV	Daily Hospital Cash Allowance as hereinafter defined ** Detailed terms & conditions as per Clause 2.12	Not Available	0.1% of Sum Insured (Rs.600 to Rs.2500) per day of Hospitalization, subject to a maximum compensation for 10 days per illness and claim being admissible under the hospitalization section of the policy. Overall liability of the Company during the Policy Period will be limited to 1.5% of the Sum Insured.
XV	Maternity expenses as hereinafter defined ** Detailed terms & conditions as per Clause 2.13	Not Available	Available for Medical Expenses for a delivery (including caesarean section) or lawful medical termination of pregnancy limited to two deliveries or terminations or either during the lifetime of the Insured Person, after the policy (Plan-B) has been continuously in force for 24 (twenty four) months. This cover is available for SI slabs equal to or greater than INR 10 Lacs.

			Liability of the Company limited to 2.5% of the Sum Insured.
XVI	Newborn Baby cover. This is subject to claim being admitted under Maternity Expenses cover ** Detailed terms & conditions as per Clause 2.14	Not Available	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the newborn baby from day one up to the age of 90days. This cover is available for SI slabs equal to or greater than INR 10 Lacs. Liability of the Company limited to 2.5% of the Sum Insured. Coverage beyond 90 days only on payment of requisite premium.
XVII	Assisted Reproduction Treatment ** Detailed terms & conditions as per Clause 2.15	Not Available	Available Upto INR 1 Lac
XVIII	Medical Second Opinion for 11 specified major Illnesses - taken from anywhere in the world. ** Detailed terms & conditions as per Clause 2.16	Maximum Rs.5000 in a Policy period.	Maximum Rs.10000 in a Policy period.
DOMICILIARY HOSPITALISATION BENEFITS			

XIX	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines &Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	10% of Sum Insured, Maximum Rs.25000/- during the Policy Period.	10% of Sum Insured, Maximum Rs. 50,000/- during the Policy Period.
XX	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)	Maximum Rs. 5,000/- actually incurred on immunization injections inany 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.	

Note: The Sum Insured levels of INR 15, 20, and 25 Lacs is available only for the entry age groups up to 65 years (Inclusive of 65 Years age) and are not available for entry age groups above 65 years. For renewals, the Sum Insured levels of INR 15, 20, and 25 Lacs are available for above 65 years age groups also.

2.2 A . 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 rateable 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.

B. **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:-**

I) Chemotherapy/Radiotherapy charges

II) Nebulisation

III) Hemodialysis

IV) PICC line insertion

V) Catheterisation charges

VI)Tracheostomy

VII) IV charges

VIII) Blood transfusion charges

IX) Dialysis

X) Surgery Charges

XI) OT charges including OT gas, equipment charges

2.3 ROAD AMBULANCE COVER :

The Policy covers the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency which occurs during the Policy Period. It becomes payable only if a claim has been admitted under Hospitalisation cover.

Policy will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:

(i) it is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;

(ii) it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of speciality treatment in the existing Hospital.

2.4 ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT :

The policy covers in-patient hospitalisation expenses in respect of the person donating the organ to the insured person, provided that the donation conforms to the Transplantation of Human Organs Act 1994 (or as amended from time to time) and/or any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. Further provided that:

i. the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant as a part of Treatment of covered disease

ii. The claim of the Insured Person is admissible under the hospitalisation section of the policy.

The policy does not cover:

a) costs directly or indirectly associated with the acquisition of the organ and/or cost of organ.

b) costs towards donor screening

c) Pre & post hospitalisation medical expenses of the donor.

2.5 PRE – HOSPITALISATION MEDICAL EXPENSES COVER :

The Policy covers, on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred due to a covered illness/disease/injury that occurs during the Policy Period upto 30 Days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:

(i) Claim for In-patient Hospitalization is admissible under terms/conditions of policy

(ii) The Pre-hospitalisation Medical Expenses are related to covered illness/disease/injury only & same illness incident for which claim of In Patient Hospitalisation was admitted.

(iii) The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.

2.6 POST – HOSPITALISATION MEDICAL EXPENSES COVER:

The Policy covers, on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred due to a covered illness/disease/injury that occurs during the Policy Period upto 60 Days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:

(i) Claim for In-patient Hospitalization is admissible under terms/conditions of policy

(ii) The Post-hospitalisation Medical Expenses are related to covered disease & same illness incident for which claim of In Patient Hospitalisation was admitted.

(iii) The date of Discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's Last Discharge from the Hospital in relation to the same Any One Illness.

2.7 IN PATIENT HOSPITALISATION COVER FOR AYUSH (Ayurvedic/Unani/ Siddha/ Homeopathic Treatment)

Policy covers the Medical Expenses incurred during the Policy period, up to the sub limits specified in the Policy Schedule/ Certificate of Insurance of an Insured Person in case of Medically Necessary Treatment taken during In-patient Hospitalization for Ayurvedic/Unani/ Siddha/ Homeopathic Treatment for an Illness or Injury that occurs during the Policy period, provided that:

The Insured Person has undergone Ayurvedic/Unani/ Siddha/ Homeopathic Treatment in :

i. A Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.

ii. Teaching hospitals of Ayurvedic/Unani/ Siddha/ Homeopathic colleges recognized by Central Council of Indian Medicine (CCIM)

iii. Ayurvedic/Unani/ Siddha/ Homeopathic Hospitals having registration with a Government authority under appropriate Act in the State/ UT and complies with the following as minimum criteria:

a. has at least fifteen in-patient beds;

b. has minimum five qualified and registered Ayurvedic doctors;

c. has qualified paramedical staff under its employment round the clock;

d. has dedicated Ayurvedic therapy sections;

e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

The amount payable under this Benefit will be a part of the Base Sum Insured.

The following exclusion will be applicable in addition to the exclusions under Section 4 :

i. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, including but not limited to beauty treatments, Panchakarma, purification, detoxification and rejuvenation.

2.8 MENTAL ILLNESS COVER:

The Company shall indemnify the Hospital or the Insured the Medical Expenses for In- patient Hospitalisation, Pre-Hospitalisation expenses and Post-Hospitalisation expenses, related to treatment of mental illness undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

- Sub limits will apply to treatment of following Mental Illnesses/Disease :

1. Major Depressive Disorder- 10% of Sum Insured
2. Acute psychotic conditions- 10% of Sum Insured.
3. Schizophrenia- 10% of Sum Insured.
4. Bipolar disorder- 10% of Sum Insured

Any kind of Psychological counselling, cognitive/ family/ group/ behaviour/ Palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

2.9 PATIENT'S ATTENDANT ALLOWANCE:

Policy indemnifies the insured's Parent/Guardian in case a dependent insured above the age of 90 days and upto the age of 10 years is Hospitalized and hospitalisation claim is admitted under the policy, as per limits mentioned under 2.1 (XI).

Rs500/- per day of Hospitalization, subject to maximum compensation for 10 days per illness. Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalization.

2.10 MODERN TREATMENT METHODS/ADVANCEMENT IN TECHNOLOGIES

The Company shall indemnify the Hospital or the Insured for the Medical Expenses (subject to sub Limits) related to following Modern Treatment Methods/Advancement in technologies :

Modern Treatment/Technology	Sub Limits	
	SI UPTO INR 10 LACS	SI GREATER THAN INR 10 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 of INR 50,000	Per policy period 10% of SI, subject to maximum of INR 1,50,000
D. Oral chemotherapy	Per policy period 25% of SI, subject to maximum of INR 50,000.	Per policy period upto INR 1,50,000.
E. Immunotherapy-Monoclonal Antibody to be given as injection	Per policy period 10% of SI, subject to maximum of INR 50,000.	Per policy period 10% of SI, subject to maximum of INR 1,50,000.
F. Intra vitreal injections	Per policy period 10% of SI, subject to maximum of INR 50,000.	Per policy period 10% of SI, subject to maximum of INR 1,50,000.
G. Robotic surgeries	Per policy period 10% of SI, subject to maximum of INR 1,00,000.	Per policy period 10% of SI, subject to maximum of INR 2,00,000.
H. Stereotactic radio surgeries	Per policy period 10% of SI, subject to maximum of INR 1,00,000.	Per policy period 10% of SI, subject to maximum of INR 2,00,000.
I. Bronchial Thermoplasty	Per policy period 10% of SI, subject to maximum of INR 1,00,000.	Per policy period 10% of SI, subject to maximum of INR 2,00,000.
J. Vaporization of the prostrate (Green laser	Per policy period 10% of SI, subject to maximum of INR	Per policy period 10% of SI, subject to maximum of INR

treatment or holmium laser treatment)	50,000.	1,50,000.
K. IONM - (Intra Operative Neuro Monitoring)	Per policy period 10% of SI, subject to maximum of INR 50,000.	Per policy period 10% of SI, subject to maximum of INR 1,50,000.
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.	Per policy period 10% of SI, subject to maximum of INR 50,000.	Per policy period 10% of SI, subject to maximum of INR 1,50,000.

2.11 TELEMEDICINE/TELECONSULTATION :

Expenses incurred by insured on telemedicine/Teleconsultation 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/Sublimits 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 limits of amount payable for telemedicine is INR 2000/- per family, for a policy period.

2.12 DAILY HOSPITAL CASH ALLOWANCE: When an Insured Person is Hospitalized and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period of 24 hours of Hospitalization, as mentioned under 2.1 (XIV) above.

2.13 MATERNITY EXPENSES: The Company shall pay the Medical Expenses incurred as an In-patient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person. This cover is available for SI slabs equal to or greater than INR 10 Lacs and available only to the Insured or his spouse, provided that:

i. Plan has been continuously in force for a period of minimum 24 months in respect of both the Insured and his/her spouse.
ii. Those Insured Persons who are already having two or more living children will not be eligible for this benefit .
iii. Liability of the Company limited to 2.5% of the Sum Insured.

2.14 NEW BORN BABY COVER: Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the newborn baby from day one up to the age of 90days.

- This cover is available for SI slabs equal to or greater than INR 10 Lacs.
- Liability of the Company limited to 2.5% of the Sum Insured.
- Coverage beyond 90 days only on payment of requisite premium.

Special conditions applicable to Maternity Expenses and New Born Baby Cover

i. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Home as in- patients in India.

ii. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.

iii. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

iv. Pre Hospitalisation and Post Hospitalisation benefits are not available under these two clauses.

2.15 .ASSISTED REPRODUCTION TREATMENT (ART):

Assisted Reproduction Treatment, is defined as the set of techniques and medical treatments that allow couples to start a family when it cannot be achieved naturally due to infertility problems. It should be proven by the specialized doctor that it is not possible to conceive through natural process due to established sub-fertility/ infertility problems of the couple.

For the scope of this policy, ART will be covering any treatment or procedure that involves the in vitro handling of human oocytes and sperm or embryos for the purpose of establishing a pregnancy.

The Company will reimburse expenses incurred on Assisted Reproduction Treatment, where indicated as mentioned above, for sub-fertility/ infertility subject to:

- A waiting period of 36 months from the date of first inception of this policy with the Company for the insured persons (both spouses). The benefit is only payable if the treatment has been initiated after the specified waiting period.
- This Benefit is only available under Plan B & maximum liability of the Company for such treatment shall be limited to INR 100000/-.
- For the purpose of claiming under this benefit, in-patient treatment is not mandatory.
- Automatic Restoration of Basic Sum Insured, Recharge benefit shall not be applicable for this benefit.

Note: To be eligible for this benefit both partners should stay insured continuously without break under this policy for every block.

This cover is limited for one child in the complete policy period only. If the

couple has one living child this benefit will not be available. This benefit will only be given once in a lifetime.

2.16 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 given in clause 2.1 above. Claim under this clause would be admissible subject to the Hospitalisation 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 Failure
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

2.17 DISEASE/PROCEDURE WISE CAPPING

SR. NO.	NAME OF THE DISEASE/PROCEDURE	LIMIT OF INDEMNITY (INR)	
		PLAN A	PLAN B
1	Cataract (including Lens)	**32000**	**40000**
2	Unilateral Total Knee Replacement (excluding implant)	**135000**	**165000**
3	Unilateral Total Hip Replacement (excluding implant)	**135000**	**165000**
4	Piles, Fistula, Fissure, Tonsillitis, Sinusitis	**20000**	**30000**
5	Benign Prostatic hypertrophy, Hernia (all types of Hernia)	**40000**	**50000**
6	Appendicitis, Gall Bladder Stones	**30000**	**40000**
7	Hysterectomy	**40000**	**50000**
		SI UPTO INR 10 LACS	**SI ABOVE 10 LACS**
1	Internal congenital diseases, genetic diseases or disorders	Per policy period 10% of SI, subject to maximum of INR 50,000.	Per policy period 10% of SI, subject to maximum of INR 1,50,000.
II	Age related macular degeneration (ARMD)	Per policy period 10% of SI, subject to maximum of INR 50,000	Per policy period 10% of SI, subject to maximum of INR 1,50,000

2.18 DEFINITION OF FAMILY :

Family consists of the Insured or Insured and any one or more of the family members as mentioned below:

a. legally wedded spouse.

b. Upto three Dependent Children (natural or legally adopted) between the ages of 91days to 18 years. However male child can be covered upto the age of 26 years if he is a bonafide regular student and financially dependent. 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 during the currency of the policy, the child above 18 years becomes

financially independent, or a male child (student) attains the age of 26 years or if the girl child gets married, he/she shall remain covered under the policy for the remainder of the policy period. However, he / she shall be ineligible for coverage in the subsequent renewal.

2.19 ENTRY AGE :

The Proposer for this Insurance should be between the age of 18 years and 70 years. Children above the age of 3 months (90 Days) can be covered by the parents / guardians provided they are financially dependent on the parents / guardians.

2.20 MIDTERM INCLUSION AND DELETION:

Midterm inclusion of following members is permitted under the Policy, only on written request and only in respect of :

i. Newly wed spouse within 90 days of marriage or at the time of renewal of the Policy.

ii. Newborn child from 1st day of Birth for policies having Sum Insured of INR 10 Lacs and above and from 91st day of birth for policies having Sum Insured less than INR 10 Lacs

or

at the time of renewal of the Policy**.**

For members subsequently added, Exclusion No. 4.1, 4.2 and 4.3 shall apply from the date of their inclusion in the policy.

2.21 COVERAGE FOR HIV / AIDS:

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

3. DEFINITIONS

3.1 ACCIDENT:

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 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.

3.3 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.

3.4 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 CLAIM FREE YEAR means coverage under the Oriental Kamgaar Suraksha Policy for a period of a year during which, no claim is paid or shall be payable under the terms and conditions of the Policy in respect of any Insured Person.

3.6 CONDITION PRECEDENT TO ADMISSION OF LIABILITY means 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.

3.7 CONGENITAL ANOMALY means condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

3.7.1 CONGENITAL INTERNAL ANOMALY means a Congenital Anomaly, which is not in the visible and accessible parts of the body.

3.7.2 CONGENITAL EXTERNAL ANOMALY means a Congenital Anomaly, which is in the visible and accessible parts of the body.

3.8 CONTRIBUTION means the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. 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 within 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 criteria as under:

- has qualified nursing staff under its employment;

- has qualified Medical Practitioner/s in charge;

- Has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

- Maintains daily record of patients and will make these accessible to the insurance company's authorized personnel.

3.10 DAY CARE TREATMENT refers to medical treatment, and/or Surgical Procedure which is:

- Undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than twenty-four hours because of technological advancement, and

- Which would have otherwise required a Hospitalization of more than twenty-four hours.

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

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 DISCLOSURE TO INFORMATION NORM:

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

3.13 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:

i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

ii) the patient takes treatment at home on account of non-availability of room in a hospital.

3.14 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.

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

a) Legally wedded spouse.

b) 2 Dependent Children (i.e. natural or legally adopted) between the age 91days to 18 years. However male child can be covered upto 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.

3.16 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.

3.17 (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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act*

OR complies with all minimum criteria asunder:

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:

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

2. The Bombay Nursing Homes Registration Act, 1949

3. The Delhi Nursing Home Registration Act, 1953

4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (Ragistrikaran Tatha Anugyapan) Adhiniyam, 1973.

5. The Manipur Homes and Clinics Registration Act, 1992

6. The Nagaland Health Care Establishments Act, 1997

7. The Orissa Clinical Establishments (Control and Regulations) Act, 1990

8. The Punjab State Nursing Home Registration Act, 1991

9. The West Bengal Clinical Establishment Act, 1950

3.17 (B) AYUSH HOSPITAL:

An 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 ofIndian Medicine/ Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system f medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practioner and must comply with all the following criterion:

i. Having at least five in- patient beds;

ii. Having qualified AYUSH Medical Practioner 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.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

Note: 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.

3.17 C AYUSH DAY CARE CENTRE:

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 Practioner (s) on day care basis without inpatient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge.

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. 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 twenty-four (24) consecutive hours of Inpatient Care except for specified procedures / treatments as mentioned in Annexure I, where such admission could be for a period of less than twenty-four consecutive hours.

3.19 INSURED PERSON means person(s) named as insured person(s) in the schedule of the policy.

3.20 ILLNESS :

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:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

2. it needs ongoing or long-term control or relief of symptoms

3. it requires rehabilitation for the patient, or for the patient to be specially trained to cope with it

4. it continues indefinitely

5. it recurs or is likely to recur

3.21 ID 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 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 of covered disease/illness/injury contracted during the currency of the Policy.

3.24 INPATIENT CARE means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.25 INTENSIVE CARE UNIT (ICU) 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.

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

3.28 INSURED PERSON means the Insured and each of the others who are covered under this Policy as shown in the Schedule.

3.29 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

3.30 MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment..

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

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii) must have been prescribed by a medical practitioner;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.32 MEDICAL PRACTITIONER is a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a state Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the Insured or close family members.

3.33 MIGRATION means, the right accorded to PNB-Oriental Royal Mediclaim -2017/OBC-Oriental Mediclaim Policy -2017 policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

3.34 NETWORK PROVIDER means Hospitals or health care providers enlisted by an insurer, TPA or jointly by insurer and TPA to provide medical services to insured by a cashless facility. The list is available with insurer/TPA and is subject to amendment from time to time.

3.35 NEW BORN BABY means baby born during the Policy Period and is aged upto 90 days.

3.36 NON-NETWORK PROVIDER means any Hospital, Day Care Centre or other provider that is not part of the Network.

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

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

3.39 PERIOD OF INSURANCE means the period for which this Policy is issued, as specified in the Schedule.

3.40 PRE-EXISTING CONDITION / DISEASE means any condition, ailment,

injury or disease:

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

3.41 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during Thirty days preceding the Hospitalisation, provided that:

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

ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.42 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during sixty days immediately after insured is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The Inpatient Hospitalisation claim is admissible by the Insurance Company.

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

3.44 PORTABILITY means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.For detailed guidelines of Portability , please refer to Para 6.7.

3.45 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.

3.46 REASONABLE AND CUSTOMARY CHARGES mean 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.

3.47 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

3.49 SUM INSURED is the maximum amount of coverage opted for each Insured Person and as shown in the Schedule.

3.50 SUBROGATION means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

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

3.52 TPA (THIRD PARTY ADMINISTRATORS) means any person who is registered under the IRDAI (Third Party Administrators - Health Services) Regulation, 2016 notified by the Authority, and is engaged, for a fee or remuneration by the Company, for the purposes of providing Health Services defined in those Regulations.

3.53 UNPROVEN/EXPERIMENTAL TREATMENT means treatment including drug, experimental therapy which is not based on established medical practice in India.

3.54 WORKER means a person employed, directly or by or through any agency (including a contractor) with or without the knowledge of the principal employer, whether for remuneration or not, in any manufacturing process, or in cleaning any part of the machinery or premises used for a manufacturing process, or in any other kind of work incidental to, or connected with, the manufacturing process, or the subject of the manufacturing process but does not include any member of the armed forces of the Union

4. GENERAL EXCLUSIONS:

4.1 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 :

A. Pre-existing Diseases - code –ExcI. 01

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.

B.Specified disease / procedure & period- code- ExcI. 02

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

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

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

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

e). If the Insured Person is continuously covered without any break as defined under the

applicable norms on portability 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	Undescendant 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 of genito-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.	**3**Years
Xxiv	Age related osteoarthritis and Osteoporosis.	**3** Years

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 4A, 4B, 4C 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 4A, 4B and 4C shall apply afresh on the enhanced portion of the Sum Insured.

C. 15 day waiting period- code – ExcI. 03

a). Expenses related to the treatment of any illness within 15 days from the first

policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

D. Investigation & Evaluation – Code – ExcI. 04

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.

E. Rest Cure, rehabilitation and respite care – Code –ExcI. 05

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

i. 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.

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

F. Obesity/Weight Control : Code- EscI. 06

Expenses related to the surgical treatment of obesity that does not fulfill all the under mentioned conditions:

1). Surgery to be conducted is upon the advice of the Doctor.

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

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

4). Body Mass Index (BMI):

a). greater than or equal to 40 or

b). 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.

G. Change of Gender Treatments : Code – ExcI. 07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

H. Cosmetic or Plastic Surgery- Code- ExcI. 08

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.

I. Hazardous or Adventure sports- Code- ExcI. 09

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.

J. Breach of law – Code –ExcI. 10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit, a breach of law with criminal intent.

K. Excluded Providers- Code – ExcI. 11

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 upto the stage of stabilization are payable, but not the complete claim.

L. Code- ExcI. 12

Treatment of Alcoholic, drug or substance abuse or any addictive condition and consequences thereof is excluded.

M. Code- ExcI. 13

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

N. Code- ExcI. 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.

O. Refractive Error- Code- Excl. 15

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

P. Unproven Treatments- Code – ExcI. 16

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.

Q. Sterility and Infertility- Code- ExcI. 17

Expenses related to sterility and infertility. This includes:

i). Any type of contraception, sterilization

ii). Gestation Surrogacy.

iii). Reversal of sterilization.

4.2 If the proposer is suffering or has suffered from any of the following diseases at the time of taking the policy, whether declared or not declared, they will be permanently excluded from the policy coverage as per serial no 1-15 of the below table:

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, polycythaemia

		vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
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 classified elsewhere. 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

4.3 Cost of external prosthetic devices, non-durable implants external medical equipment.

4.4 Dental treatment or Surgery of any kind unless necessitated due to Accident.

4.5 Kaposi Sarcoma.

4.6 Any expenses relating to cost of items detailed in List 1 of **Annexure A.**

4.7 Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.

4.8 Treatment including investigation/diagnostic services availed outside India

4.9 Specified healthcare providers :

- Treatment rendered by a Medical Practitioner, which is outside his discipline or the discipline for which he is licensed.
- Treatments rendered by a Medical Practitioner, who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

4.10 Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments that are not supported by treating doctor's prescription.

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

4.12 Any non-medical expenses mentioned on our website and or attached with this policy.

5. CONDITIONS

5.1 BASIS OF INSURANCE:

This Policy is issued based on the truth and accuracy of statements in the Proposal. If there is any misrepresentation or non-disclosure of material facts, the Company will treat the Policy as void ab initio.

5.2 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

5.3 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.

5.4 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 payment of premium and the observance and fulfilment 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.

5.5 PLACE OF TREATMENT AND PAYMENT:

- This Policy covers Medical/ Surgical treatment and/or services rendered in India.

- Admissible claims shall be payable only in Indian Rupees.

- Payment shall be made directly to Network Hospital if Cashless facility is availed. If request for Cashless facility is not availed/approved, bills and Mandatory documents will be required to be submitted for reimbursement.

Note: Cashless facility is only a mode of claim payment and cannot be demanded in every claim. In case admissibility of a claim is disputed at the initial stage and warrants further verification/investigation of treatment, records etc., request for Cashless facility may be declined. Insurer's decision in this regard will be final.

Denial of Cashless facility would not imply denial of claim. If Cashless facility is denied, Insured may submit the papers on completion of treatment and admissibility of the claim would be subject to the terms, conditions and exclusions of the Policy.

5.6 CLAIMS PROCEDURE:

A. NOTIFICATION OF CLAIM:

Immediate written 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 or by any other mode of communication.

Such notice should be Communicated/ delivered to Company by Insured/Insured's representative within prescribed time lines as under :

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization

- Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the insurer 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.

B. PROCEDURE FOR AVAILING CASHLESS TREATMENT/ SERVICES IN NETWORK HOSPITAL/NURSING HOME:

i. Cashless Treatment may be availed through TPA in a network provider/PPN hospital and is subject to preauthorization by the TPA. List of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is also available on website of the company (https://orientalinsurance.co.in)

ii. The name and complete contact details of policy servicing TPA are mentioned on the front page of policy schedule. In case of more details, insured can log on to website of TPA or details can be accessed by logging on to our website under the below mentioned path:

www.orientalinsurance.org.in - Products - Health insurance - Empanelled TPA

iii. Insured may call TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.

iv. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA or Policy Schedule at the Hospital Insurance-desk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for pre- authorization.

V. 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 in-patient.

vi. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Insurer or the associated TPA, Insurer will make the payment of the amounts assessed directly to the Network Provider.

vii. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under point no. iv above.

viii. At the time of discharge, the insured person shall verify and sign the discharge papers and final bill and pay for non-medical and inadmissible expenses.

Note: (Applicable to 5.6 B): For all cashless authorisations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and / or opted Deductible (Per claim/ Aggregate/ Corporate) (if applicable), directly with the Hospital.

ix. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA/Insurer for possible reimbursement within 15 days of the discharge from Hospital / Nursing Home for consideration of TPA/Insurer.

x. In case of admission in PPN hospitals, duly filled and signed PPN declaration format available with the hospital must be submitted.

xi. 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.

xii. Claims for Pre and Post-Hospitalisation (as per limits prescribed in the policy) will be settled on reimbursement basis on production of cash receipts along with supporting documents.

C. **PROCEDURE FOR REIMBURSEMENT OF CLAIMS:**

In case insured has availed treatment In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

D . **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 Fifteen (15) days of discharge from the Hospital / Nursing Home:

i. Duly completed claim form

ii. Photo ID and Age proof;

iii. All previous consultation papers indicating history and treatment details for current ailment;

iv. Copy of indoor case papers with nursing sheet(If Available) detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

v. Numbered Bill, Receipt and Discharge certificate / card from the Hospital.

vi. Numbered Cash Memos from the Hospitals(s) / Chemists(s), supported by proper prescriptions.

vii. Numbered Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such tests.

viii. Surgeon's certificate stating nature of operation performed and Surgeons' numbered bill and receipt.

ix. Attending Medical Practitioner's / Anaesthetist's numbered bill and receipt, and certificate regarding diagnosis.

x. Copy of PAN Card and NEFT Details.

xi. 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.

xii. Authorisation Letter to TPA to obtain medical and other records from any Hospital, Laboratory or other agency.

xiii. Any other information/document/data required by Insurer/TPA

Note: All the documents have to be in original & self attested. If the originals have been submitted to some other company, certified & self attested true copy of the same along with the settlement note should be submitted.

In case of Post-Hospitalisation treatment (limited to ninety days), all claim documents should also be submitted to TPA/Insurer within fifteen (15) days after completion of such treatment. (Up to Ninety Days or actual period, whichever is less)

Time Limit for Submission of Claim Documents will be as under:

Type of claim	**Time limit for submission of documents to company/TPA**
Where Cashless Facility has been authorised	Immediately after discharge
Reimbursement of hospitalisation and pre hospitalisation expenses (limited to 45 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 15 (fifteen) days from completion of post hospitalisation treatment

The above stipulations are not intended to prejudice insured's claim, but their compliance is of utmost importance and necessity for insurer/TPA to identify and verify all facts and surrounding circumstances relating to a claim and determine its admissibility as per terms & conditions of the policy.

Waiver of delay in submission of claim documents may be considered in genuine cases of hardship, but only if it is proved to insurer's satisfaction that it was not possible for insured or any other person to comply with the prescribed time-limit.

The Insured person shall give the TPA/Insurer any additional information and assistance as the TPA / Insurer may require.

E. **SCRUTINY OF CLAIM DOCUMENTS:**

i. TPA/ Insurer shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/ Network Provider as the case may be. If the deficiency in the necessary claim documents is not met or is partially met in 10 working days of the first intimation, Insurer/TPA will send a maximum of 3 (three) reminders. Insurer /TPA may, at its sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if insurers observe that such a claim is otherwise valid under the Policy.

ii. In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network

Provider whether the pre-authorisation has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

iii. The Pre-Hospitalisation Medical Expenses Cover claim and Post- Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

iv. In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.

v. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.

vi. The claim shall be eligible for repudiation if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder. If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.

F. **CLAIM SETTLEMENT(PROVISION OF PENAL INTEREST):**

i. 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.

ii. 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.

iii. However, where the circumstances 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 the claim within 45 days from the date of receipt of last necessary document..

iv. In case of delay beyond stipulated 45 days, 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)..

vi. Insurer shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.

vii. Insurers are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.

viii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

ix. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

x. **For Cashless claims,** the payment shall be made to the Network Provider whose discharge would be complete and final.

xi. **For Reimbursement claims,** the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, insurers will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of insurer's liability under the Policy.

5.7 CONTRIBUTION:

i) 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.

ii) 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 rateable proportion of the admissible claim.

iii) The Insured Person is duty bound to disclose such other insurance at the time of making a claim under this policy.

5.8 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 of the expiring Policy only.

Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

5.9 REPUDIATION/REJECTION OF CLAIM:

a) If Insurer, for any reasons, decides to reject a claim under the policy, insurer shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.

b) Where a rejection is communicated by Insurer, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision represent to insurer for reconsideration of the decision.

c) 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.

d) If the insured is not satisfied with the reply of the Customer Service department under 5.9 (c), 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 upto INR 20 Lacs.

5.10 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 hereunder.

5.11 ARBITRATION CLAUSE :

i. 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.

ii. 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.

iii. 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.

5.12 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 made under the policy which are found fraudulent later under this policy shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment.

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

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

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

(c) any other act fitted to deceive; and

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

The company shall not repudiate the 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.

5.13 MEDICAL RECORDS :

a) 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 thereunder.

b) The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and will only use it in connection with any claim made under this Policy or the Company's liability thereunder.

c) Independent Medical Practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any Treatment/claim preferred under this policy ,when and so often as the same may reasonably be required on behalf of the Company/TPA.

5.14 CANCELLATION CLAUSE:

A) CANCELLATION BY INSURER:

The Company may cancel the Policy at any time on grounds of mis-represenation, 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 mis-represenation ,non-disclosure of material facts or fraud.

B) CANCELLATION BY INSURED:

The Policyholder may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period as per the rates detailed below :

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six 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.

6. OTHER TERMS AND CONDITIONS:

6.1 ENHANCEMENT OF SUM INSURED: Increase in Sum Insured under the Policy may be considered by the Company only at the time of renewal. If at all allowed, increase shall be as given below:

a. On Renewal, Sum Insured can be increased to the immediate higher slab.

b. If size of the family increases on Renewal, Sum Insured can be increased to maximum two slabs higher.

c. If there are no claims reported in the two immediate preceding Policy

Periods, change to the next Plan at the initial Sum Insured slab, or two steps higher from the current Sum Insured, whichever is more, is allowed.

d. Notwithstanding above provisions, no increase in Sum Insured is allowed in policies

- where there are claims reported consecutively in the two immediately preceding Policy Periods.
  OR
- where any one of the insured persons is above the age of 80 years.

6.2 FREE LOOK PERIOD:

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.
The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

6.3 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.

6.4 RENEWAL OF POLICY:

i. The policy shall ordinarily be renewable for a further period of one year except on grounds of fraud, misrepresentation by the insured person.
ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy Period,
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
v. At the end of the Policy Period, the policy shall terminate and can be renewed within

the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

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

6.5 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. This condition is only for policies with a policy period of one year,

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 atleast 30 days before the policy renewal date as per IRDAI (Insurance Regulatory and Development Authority of India) guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under PNB-Oriental Royal Mediclaim -2017/OBC-Oriental Mediclaim Policy -2017, the insured person will get the accrued continuity benefits in waiting period as per IRDAI guidelines on migration. This clause is applicable for policies with a duration of one year.

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 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, atleast 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.

Further to the above referred guidelines, for seamless coverage with continuity of benefits to the account holders of various banks who are provided health insurance coverage through group insurance schemes, the following guidelines are hereby issued.

a. Members of an indemnity-based group health insurance policy offered to account holders of a bank are allowed portability of their coverage to another indemnity based group health insurance policy offered by a different insurer to the account holders of the same bank.

b. The portability will be offered subject to the option exercised by an individual member of the group policy.

c. All our existing policyholders insured under PNB-Oriental Royal Mediclaim - 2017/OBC-Oriental Mediclaim Policy -2017 will have an option to port/migrate their policy to Oriental Insurance Bank Saathi policy subject to applicable terms, conditions & guidelines in this regard.

For Detailed Guidelines on Portability, kindly refer the link:

https://www.irdai.gov.in/ADMINCMS/cms/LayoutPages_Print.aspx?page=PageNo4257

6.8 CHANGE OF ADDRESS:

Insured must inform the Company immediately in writing of any change in the address.

6.9 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)

6.10 WITHDRAWAL OF POLICY:

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.
iii. This clause is applicable for policies with a duration of one year.

6.11 MORATORIUM PERIOD:

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

6.13 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations2016 & Guidelines on Standardization in health insurance, as amended from time to time.

6.14 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

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.

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

6.15 MULTIPLE POLICIES:

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder 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 policy holder 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.
2. Policyholder 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.

3. If the amount to be claimed exceeds the sum insured under a single policy, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.
5. Proposer is not allowed to take multiple policies of Oriental Kamgaar Suraksha. This condition shall be applicable to all the Insured persons covered under Oriental Kamgaar Suraksha Policy.

6.16 COMPLETE DISCHARGE :

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6.17 DISCLOSURE TO INFORMATION NORM:

The policy shall be void and all premiums 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.

6.18 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. ln 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.

6.19 ASSIGNMENT :As per the provisions of Sec. 38 (1) of Insurance Act, 1938.

6.18 TERRITORIAL 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.

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ANNEXURE I – LIST OF DAY CARE PROCEDURES/SURGERIES

A	**Microsurgical Operations on the Middle Ear**
1	Stapedotomy
2	Stapedectomy
3	Revision of a stapedectomy
4	Myringoplasty (Type -I Tympanoplasty)
5	Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6	Revision of a tympanoplasty
B	**Other operations on the middle & internal ear**
7	Myringotomy
8	Removal of a tympanic drain
9	Incision of the mastoid process and middle ear
10	Mastoidectomy
11	Reconstruction of the middle ear
12	Fenestration of the inner ear
13	Revision of a fenestration of the inner ear
14	Incision (opening) and destruction (elimination) of the inner ear
C	**Operations on the nose & the nasal sinuses**
15	Excision and destruction of diseased tissue of the nose
16	Operations on the turbinates (nasal concha)
17	Nasal sinus aspiration
D	**Operations on the eyes**
18	Incision of tear glands
19	Incision of diseased eyelids
20	Excision and destruction of diseased tissue of the eyelid
21	Operations on the canthus and epicanthusv
22	Corrective Surgery for entropion and ectropion
23	Corrective Surgery for blepharoptosis
24	Removal of a foreign body from the conjunctiva
25	Removal of a foreign body from the cornea
26	Incision of the cornea
27	Operations for pterygium
28	Removal of a foreign body from the lens of the eye
29	Removal of a foreign body from the posterior chamber of the eye
30	Removal of a foreign body from the orbit and eyeball
31	Operation of Cataract
E	**Operations on the skin & subcutaneous tissues**
32	Incision of a pilonidal sinus
33	Free skin transplantation, donor site

34	Free skin transplantation, Recipient site
35	Revision of skin plasty
36	Simple restoration of surface continuity of the skin and subcutaneous tissues
37	Destruction of diseased tissue in the skin and subcutaneous tissues
38	Local excision of diseased tissue of the skin and subcutaneous tissues
39	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
40	ChemoSurgery to the skin
F	**Operations on the tongue**
41	Incision, excision and destruction of diseased tissue of the tongue
42	Partial glossectomy
43	Glossectomy
44	Reconstruction of the tongue
G	**Operations on the salivary glands & salivary ducts**
45	Incision and lancing of a salivary gland and a salivary duct
46	Excision of diseased tissue of a salivary gland and a salivary duct
47	Resection of a salivary gland
48	Reconstruction of a salivary gland and a salivary duct
H	**Other operations on the mouth & face**
49	External incision and drainage in the region of the mouth, jaw and face
50	Incision of Hard & Soft Palate
51	Excision and destruction of diseased hard and softpalate
52	Incision, excision and destruction in the mouth
53	Plastic Surgery to the floor of the mouth
54	Palatoplasty
I	**Operations on the tonsils & adenoids**
55	Transoral incision and drainage of a pharyngeal abscess
56	Tonsillectomy without adenoidectomy
57	Tonsillectomy with adenoidectomy
58	Excision and destruction of a lingual tonsil
J	**Trauma Surgery and orthopaedics**
59	Incision on bone, septic and aseptic
60	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
61	Reduction of dislocation under GA
62	Arthroscopic knee aspiration
K	**Operations on the breast**
63	Incision of the breast
64	Operations on the nipple
L	**Operations on the digestive tract**
65	Incision and excision of tissue in the perianal region
66	Surgical treatment of anal fistulas
67	Surgical treatment of hemorrhoids
68	Division of the anal sphincter (sphincterotomy)
69	Ultrasound guided aspirations

70	Sclerotherapy
M	**Operations on the female sexual organs**
71	Incision of the ovary
72	Insufflation of the Fallopian tubes
73	Dilatation of the cervical canal
74	Conization of the uterine cervix
75	Incision of the uterus (hysterotomy)
76	Therapeutic curettage
77	Culdotomy
78	Incision of the Vagina
79	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
80	Incision of the vulva
81	Operations on Bartholin's glands (cyst)
N	**Operations on the prostate & seminal vesicles**
82	Incision of the prostate
83	Transurethral excision and destruction of prostate tissue
84	Transurethral and percutaneous destruction of prostate tissue
85	Open surgical excision and destruction of prostate tissue
86	Radical prostate vesiculectomy
87	Incision and excision of periprostatic tissue
88	Operations on seminalvesicles
O	**Operations on the scrotum & tunica vaginalis testis**
89	Incision of the scrotum and tunica vaginalis testis
90	Operation on a testicular hydrocele
91	Excision and destruction of diseased scrotal tissue
92	Plastic reconstruction of the scrotum and tunica vaginalis testis
P	**Operations on the testes**
93	Incision of the testes
94	Excision and destruction of diseased tissue of the testes
95	Unilateral orchidectomy
96	Bilateral orchidectomy
97	Orchidopexy
98	Abdominal exploration in cryptorchidism
99	Surgical repositioning of an abdominal testis
100	Reconstruction of the testis
101	Implantation, exchange and removal of a testicular prosthesis
Q	**Operations on the spermatic cord, epididymis und ductus deferens**
102	Surgical treatment of a varicocele and a hydrocele of the spermatic Cord
103	Excision in the area of the epididymis
104	Epididymectomy
105	Reconstruction of the spermatic cord
106	Reconstruction of the ductus deferens and epididymis
R	**Operations on the penis**
107	Operations on the foreskin

108	Local excision and destruction of diseased tissue of the penis
109	Amputation of the penis
110	Plastic reconstruction of the penis
S	**Operations on the urinary system**
111	Cystoscopical removal of stones
T	**Other Operations**
112	Lithotripsy
113	Coronary angiography
114	Haemodialysis
115	Radiotherapy for Cancer
116	Cancer Chemotherapy

Annexure-A

List I – Items for which coverage is not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES

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

List II – Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT

28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT

11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

ANNEXURE II: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Area of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka.	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in

Orissa.	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi.	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan.	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363
Area of Jurisdiction	**Office of the Insurance Ombudsman**
Kerala, Lakshad weep, Mahe-a part of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in

West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun,	Office of the Insurance Ombudsman,

Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in