THE ORIENTAL INSURANCE COMPANY LIMITED

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

Oriental Super Health Top-Up!

1. The basis of this contract is the proposal form and declaration given by the insured named in the Schedule, and which is deemed to be incorporated herein; and through which the insured has applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the Company) for the insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (hereinafter called the **INSURED PERSON** (S)) and has paid premium to the Company as consideration for such insurance. The insurance shall be serviced by Third Party Administrator (hereinafter called the **TPA**).

   Subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the period of insurance stated in the Schedule, any Insured Person(s) contracts or suffers from any illness / ailment / disease (hereinafter called '**DISEASE**') or sustains any bodily injury through accident (hereinafter called '**INJURY**') and if such disease or injury shall require any such Insured Person(s), upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called **MEDICAL PRACTITIONER**) or of a duly qualified Surgeon (hereinafter called '**SURGEON**') to incur expenses on hospitalisation (as defined hereinafter) for medical/surgical treatment at any Nursing Home/Hospital (hereinafter called '**HOSPITAL**') as an inpatient in India (or in SAARC countries), the Company will pay to the Hospital(s) (only if treatment is taken at Network Hospital(s) with prior written approval of Company / TPA) or reimburse to the Insured Person, as the case may be, the amount of such admissible expenses, as specified hereunder. It is a **condition precedent** that the expenses incurred in respect of **medically necessary treatment**, **are reasonable and customary**; and in any case the liability of the Company, in respect of one or all the **Insured Persons** stated in the schedule, shall be in excess of the Deductible and upto the Sum Insured specified in the policy and/or schedule of the policy, for all claims arising during the policy period mentioned in the schedule.

1.2. BASIS OF PAYMENT: The Company shall indemnify the insured, subject to

a. aggregate of all admissible expenses incurred exceeding the Deductible but not exceeding the Sum Insured, under this policy and
b. dates of admission in the hospital falling within the policy period.

	Insured Expenses	Limits of Insured Expenses
		HOSPITALISATION EXPENSES
	Room, Boarding and Nursing E provided by the Hospital /Nursin	1 % of the Deductible Amount (mentioned in the Policy Schedule) per day. *
	Intensive Care Unit (**ICU**) expen provided by the Hospital /Nursin	2 % of the Deductible Amount (mentioned in the Policy Schedule) per day.*
	a. Number of days of stay under 'i' and 'ii' above should not exceed total number of days of stay in the Hospital as specified in iii and iv below shall also be payable as per the entitled room rent limit as mentioned above. medicines / pharmaceuticals and body implants would be payable on actual basis. b. Any expense in excess of reasonable and customary charges as defined under 3.40, or in excess of negotiated case of network hospitals) shall be borne by the insured.	
	Surgeon, Anesthetist, Medical P Consultants, Specialists Fees	within the limits of Sum Insured, subject to 'a' & 'b' above

	Expenses in respect of Anesthe Oxygen, Operation Theatre Surgical Appliances, Medicines Diagnostic Material and X-Ray Chemotherapy, Radiotherapy, Pacemaker, Artificial limbs and expenses.	within the limits of Sum Insured, subject to 'a' & 'b' above
	Organ Donor Benefit when Insur is Donor.	Lumpsum payment of 10% of the Sum Insured.
	Donor Expenses when Insured P Recipient	within the limits of Sum Insured
	Pre and Post hospitalisation expe	Medical expenses incurred 30days prior to hospitalisation and upto 60 days po hospitalisation.
	Telemedicine	i). Maximum Rs. 2,000/- per insured &/or per family, for a policy period for su upto Rs. 20.0 lakhs and ii). Maximum Rs. 5,000/- per insured &/or per family, f period for sum insured upto Rs. 30.0 lakhs.

***Deletion of Room Rent Limit:** These limits are not applicable if the insured has paid the requisite additional premium for removal of Room Rent limits. In such a case, room rents and expenses in respect of iii & iv above, become payable on actuals basis, subject to other terms & conditions of the policy.

B. Relaxation to 24 hours minimum duration of hospitalisation is allowed in

a. specified Day Care procedures / Surgeries (as per appendix-I) where such treatment is taken by an Insured Person in a Hospital / Day Care Centre (but not the Out-Patient department of a hospital), Or
b. any other Day Care Treatment as mentioned in clause 3.11 and for which prior approval from Company / TPA is obtained in writing.

C. 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.

NOTE: Maximum liability of the Company under the policy is the Sum Insured stated in the schedule.

2 A. INSURED EXPENSES

1. **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
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. **ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR**: A lumpsum payment of 10% of Sum Insured, to take care of medical and other incidental expenses is payable to the Insured Person donating an organ, provided that the donation conforms to the Transplantation of Human Organs Act 1994(as amended from time to time) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. This benefit is available only to the Insured person provided that this policy has been in force for a continuous period of minimum 24 months in respect of such an insured person.

This lumpsum payment will be made even if the Deductible has not been exceeded, and will be in addition to any amount payable under this head in any other Policy / or any other source. However, payment made under this section shall be within the Sum Insured limit of the Policy.

3. **MATERNITY EXPENSES:** The policy provides automatic maternity cover upto 10% of the Sum Insured. The Company shall pay the Medical Expenses incurred as an inpatient 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. Cover under this section is not available to those insureds who already have two living children. This benefit is available only to the Insured or his spouse provided that this policy has been in force for a continuous period of minimum 12 months in respect of both the Insured and his/her spouse. However, miscarriage due to accident or abdominal operation for extra uterine pregnancy (ectopic

pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated, is not part of maternity coverage and hence no waiting period would apply in such cases.

4. **NEW BORN BABY COVER**: This benefit is available only if both the insured and his/her spouse are covered under the family floater plan / Individual plan of the Policy, as the case may be. The policy provides automatic cover upto 5% of the Sum Insured to the new born baby upto 90days from the date of birth. Cover beyond 90 days is available for full Sum Insured only on payment of requisite additional premium.

In case the 90 days period for the New Born Baby is spread over two policy periods, the aggregate liability of the Company, for all claims in respect of the New Born Baby, shall be limited to 5% of the Sum Insured of the policy under which the claim had triggered.

Claim under this section is independent of the claim status in respect of Maternity expenses, i.e admissibility or otherwise of claim under 2A3 will not affect the claim in respect of **New Born Baby**

Special conditions applicable to Maternity Expenses and New Born Baby Cover

i. These benefits are admissible only if the expenses are incurred in a Hospital as an in-patient.
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 and treatment is taken there. Prenatal is the medical care given to a pregnant woman and for the purpose of this policy it starts from the date of conception upto the childbirth. Post natal is the medical care given to a woman after her baby is born and coverage is for a period of six weeks from the date of childbirth.
iv. Pre Hospitalisation and Post Hospitalisation benefits are not available under these two clauses.
v. Subject to the terms & conditions, the policy covers New Born Baby beyond 90 days only on payment of requisite premium.

Note: **Coverage under 3 & 4 above**: In case of family floater plan, the policy Sum Insured would be considered for arriving at the sublimit of 10% & 5% for coverage under 3& 4 respectively, and in case of individual plan, Sum Insured of the insured mother would be considered.

Company's overall Liability in respect of all claims admitted under clause **1.2** (I), **2A (1, 2, 3 and 4)** during the policy period shall not exceed the Sum Insured mentioned in the Schedule.

5. **Telemedicine-** 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 limit of amount payable for telemedicine is: i). Maximum Rs. 2,000/- per insured &/or per family, for a policy period for sum insured upto Rs. 20.0 lakhs and ii). Maximum Rs. 5,000/- per insured &/or per family, for a policy period for sum insured upto Rs. 30.0 lakhs.

   Note: The expenses towards Telemedicine will be payable, only if, they form part of Pre and Post Hospitalization and/or Hospitalization claims.

6. **COVERAGE TO SAARC COUNTRIES:** The policy automatically covers Insured Persons visiting other SAARC (South Asian Association for Regional Co-operation) countries viz- Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka. However Cashless service will not be available for treatment taken in countries outside India and such claims shall be considered only on re-imbursement basis on the return of the insured person to India. All other conditions in respect of claim shall apply as such.
7. **HIV/ AIDS Cover**

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) related to following stages of HIV infection:

a. Acute HIV infection – acute flu-like symptoms
b. Clinical latency – usually asymptomatic or mild symptoms
c. AIDS – full-blown disease; CD4 < 200

8. **MENTAL ILLNESS COVER**

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

1. Illness covered under definition of mental illness mentioned under clause 3.29.
2. Hospitalization in Mental Health Establishment as defined under clause 3.30.
3. Hospitalization as advised by Mental Health Professional as defined under clause 3.31.
4. Mental Conditions associated with the abuse of alcohol and drugs are excluded.
5. Mental Retardation and associated complications arising therein are excluded.
6. Any kind of Psychological counseling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalization is not necessary shall not be covered.

9. **All the following procedures, will be covered in the policy, if treated as in-patient care or as day care treatment in the hospital, within the sub-limits in the complete policy period which is as defined below:**

Name of the Procedure	**Sub limits for sum insured slab fro lakhs to Rs. 10.0 lakhs**	**Sub limits for sum insured slab from lakh to Rs. 30.0 lakhs**
A. Uterine Artery Embolization and	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, s maximum INR 50,000.	Per policy period 10% of SI, s maximum INR 1,50,000.
D. Oral chemotherapy	Per policy period 25% of SI, s maximum INR 50,000.	Per policy period: Up to INR 1,50,000
E. Immunotherapy- Monoclonal An be given as injection	Per policy period 10% of SI, s maximum INR 50,000.	Per policy period 10% of SI, s maximum INR 1,50,000.
F. Intra vitreal injections	Per policy period 10% of SI, s maximum INR 50,000.	Per policy period 10% of SI, s maximum INR 1,50,000.
G. Robotic surgeries	Per policy period 10% of SI, s maximum INR 1,00,000.	Per policy period 10% of SI, s maximum INR 2,00,000.
H. Stereotactic radio surgeries	Per policy period 10% of SI, s maximum INR 1,00,000.	Per policy period 10% of SI, s maximum INR 2,00,000.
I. Bronchial Thermoplasty	Per policy period 10% of S to maximum INR 1,00,000.	Per policy period 10% of SI, maximum INR 2,00,000.
J. Vaporization of the (Green laser treatment or laser treatment)	Per policy period 10% of S to maximum INR 50,000.	Per policy period 10% of SI, maximum INR 1,50,000.
K. IONM - (Intra Operati Monitoring)	Per policy period 10% of S to maximum INR 50,000.	Per policy period 10% of SI, maximum INR 1,50,000.
L. Stem cell therapy: Hem stemcell conditions to be covered.	Per policy period 10% of S to maximum INR 50,000.	Per policy period 10% of SI, maximum INR 1,50,000.

2B. POLICY TRIGGER: This policy would trigger when the aggregate of actual admissible expenses incurred in respect of any one or more claims (either for an Individual in case of an Individual plan, or for one or more than one insured person, in case of a Family Floater plan) in a policy period, exceeds the Deductible under the Policy.

If there are other sources (other than Insurance policies) from where the Insured Person can receive an amount which is greater than the Deductible, the Insured Person has the option either to exhaust other options first and subsequently claim under this Policy; or to first claim under this Policy. If the Insured Person chooses to first claim under this Policy, and if subsequently he receives reimbursement from other sources for any amount which has also been paid under this Policy, the Insured Person shall refund to the Company such excess payment.

In no case shall the liability of the Company exceed the Sum Insured for one or all claims in aggregate during the policy period.

2C. WORKING OF ADMISSIBLE CLAIM AMOUNT: This policy would trigger when the aggregate of admissible expenses incurred exceed the Deductible under the policy. This means that all the claims, including those falling within the Deductible, will be assessed based on the terms and conditions of this policy for working out the admissible expenses. Expenses related to pre-hospitalisation & post-hospitalisation in respect of all previous

claims would also be taken into consideration.

If the insured's policy has Room rent capping, then expenses as stated in 1.2 IA would be linked to the entitled room rent limit. So, if the room availed by the insured person has a higher rent than the room rent limit as per his policy, the Insured would have to bear the difference between what he has actually incurred and what he is entitled for (in terms of room rent and associated expenses), as per his policy's room rent limit.

Claim admissibility will be decided based on the terms and conditions of this Policy. Admissibility of claim would be worked out only if the insured expenses, in aggregate, have exceeded or are likely to exceed the Deductible. If the claim is admissible as per the policy terms and conditions, the maximum amount payable (admissible claim amount) under the policy would be that amount which is in excess of the Deductible, subject to Company's liability not exceeding the Sum Insured.

Illustration:

- Deductible chosen – Rs.3lakhs
- Sum Insured chosen – Rs.5lakhs

		How the Claim payment will be considered
Case 1:	There is one single hospitalisation in period. Hospitalisation expense is Rs.3lakhs Pre & post hospitalisatio incurred is Rs.1lakh. Total incurred expenses – Rs.4lakhs	Scenario 1: Admissible expenses is Rs.2.50lakhs, which is Deductible so nothing is payable under the policy. Scenario 2: Admissible expenses is Rs.3.50lakhs, which ha the Deductible by Rs.50,000, so the amount payable under is Rs.50,000.
Case 2:	There are multiple claims under the p Claim no.1: Hospitalisation expense is Rs.2lakhs Pre & post hospitalisatio incurred is Rs.1lakh. Total incurred e	Scenario 1: There are two claims under the policy, Claim Admissible expenses under Claim no.1 is Rs.2.lakhs and u no.2, it is Rs.1.40lakhs. So the total admissible expenses policy considering both the claims is 3.40lakhs, which ha the Deductible by Rs.40,000, so the amount payable under is Rs.40,000 in respect of Claim no.2.
	Rs.3lakhs Claim no.2: Hospitalisation expense is Rs.1.75lakhs Pre & post hospitalisation expenses Rs.0.5lakh. Total incurred expenses – Rs.2.25lak	Scenario 2: The above is an example where Room rent is Deductible. Now suppose, the insured's policy does not have capping, then Admissible expenses under Claim no.1 is Rs and under Claim no.2 it is Rs.2lakhs. Thus the total expenses under the policy considering both the claims, is which has exceeded the Deductible by Rs.1.75lakhs, so t payable under the policy is Rs.1.75lakhs in respect of Clai

Case 3:	Claim no.1: This is the first hospitalis policy period. Hospitalisation incurred in respect of a pre-existing Rs.4.50lakhs Pre & post hospitalisation expenses Rs.1lakh. Total incurred expenses – Rs.5.50lak Claim no.2: Hospitalisation expense is Rs.1.75lakhs. Pre & post hosexpenses incur Rs.0.65lakhs. Total incurred expenses – Rs.2.40lak Claim no.3: Hospitalisation expense is Rs.1.75lakhs. Pre & post hosexpenses incur Rs.0.75lakhs. Total incurred expenses – Rs.2.50lak	Scenario 1: Claim No.1 relates to pre-existing disease admissible since it relates to Pre-existing disease. Claim No.2 has not exceeded the Deductible, hence nothing though the disease does not fall under any exclusion. In w the payable amount for claim No.2, we will not consider Cl all, since it falls under exclusion of pre-existing disease admissible under the policy. It is of no concern whether insured's claim (no.1) has been paid under the Base policy. Aggregate of Claim Nos. 2&3 has exceeded the Deductible Admissible expenses under Claim no.2, Rs.2.10lakhs and u no.3 it is Rs.2.20lakhs. Now the aggregate is Rs.4.30lakhs, exceeded the Deductible by Rs.1.30lakhs. So the amou under the policy is Rs.1.30lakhs in respect of Claim no.3. Scenario 2: The above is an example where Room rent is Deductible. Now suppose, the insured's policy does not have capping, then Admissible expenses under Claim no.2 is Rs and under Claim no.3 it is Rs.2.30lakhs. Thus the total expenses under the policy considering both the claims, is which has exceeded the Deductible by Rs.1.50lakhs, so t payable under the policy is Rs.1.50lakhs in respect of Clai
Case 4	There is one single hospitalisation in the policy period. Hospitalisation expense is Rs.8.50 lakhs Pre & post hospitalisation expenses Rs.1lakh. Total incurred expenses – Rs.9.50lak	Admissible expenses is Rs.8.30 lakhs, which has exceeded the Deductible by Rs.5.30lakhs. Sum Insured is Rs.5lakhs. So, the admissible expenses after consi Deductible, is Rs.5.30lakhs, which is greater than the Su (Rs.5lakhs). However, the maximum admissible claim amou cannot exceed the Sum Insured under the policy. Hence amount payable in this case under the policy is Rs.5 and not Rs.5.30lakhs.
Case 5:	There is one single hospitalisation i policy (i.e in the second renewal) in **donation of one kidney** by the ins father. Hospitalisation expenses in Rs.0.45 lakhs. Pre & post hospitalisation Rs.1lakh. Total incurred expenses – Rs.1.45 la	Since this relates to Organ Donor by the Insured Person, hos in respect of him, does not get paid. However, the policy would still pay him a lumpsum of 10% Insured, as per clause 2A2 which would be Rs.50,000 in t

3. **DEFINITIONS**:

Accident: is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Admissible Expenses: are those expenses, which conform to the insured expenses as per the terms and conditions

of the policy.

Admissible Claim Amount: means the amount payable under the policy, upto the Sum Insured, after applying the deductible and sub-limits, wherever applicable.

AYUSH: AYUSH treatment refers to the Medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems.

Cashless Facility: means a facility extended by the insurer or TPA on behalf of the Insurer to the insured, where the payments for the costs of the 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 of pre- authorization is approved.

Congenital Anomaly: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly: which is not in the visible and accessible parts of the body
b. External Congenital Anomaly**:** which is in the visible and accessible parts of the body

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

Deductible: is a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies, and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

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

Day Care Centre: means any institution established for day care treatment of illness and /or injuries OR a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a. has qualified nursing staff under its employment,
b. has qualified medical practitioner (s) in charge,
c. has a fully equipped operation theatre of its own, where surgical procedures are carried out
d. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Day Care Treatment: means medical treatment, and/or surgical procedure which is:

a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
b. which would have otherwise required a hospitalization of more than 24 hours. Treatments normally taken on an out-patient basis is not included in the scope of this definition.

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

a. legally wedded spouse.
b. Parents / Parents-in-law (either of them)
c. Dependent Children- natural or legally adopted, between the ages of 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 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 25 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 renewals and will have to apply for coverage under an independent policy.

d. There is no upper age limit for dependent children who are physically or mentally challenged.

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.

HOSPITAL/NURSING HOME: 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

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 of 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.

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.

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.

Hospitalisation: means admission in a Hospital for a minimum period of twenty four (24) in- patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

I.D.Card: means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

Illness: means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

a.Acute condition - 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 - is a disease, illness, or injury that has one or more of the following characteristics:

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

iv. it needs ongoing or long-term control or relief of symptoms
v. it requires rehabilitation or to be specially trained to cope with it
vi. it continues indefinitely
vii. it comes back or is likely to come back.

In-Patient: means an Insured Person who is admitted to Hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

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

(a) 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.

(b) 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.

IRDAI: is Insurance Regulatory and Development Authority of India, and regulates the insurance business in India.

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

Insured Person: means Person(s) named as Insured Person(s) on the schedule of the Policy.
Maternity Expenses: shall include (a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during hospitalisation (b) expenses towards lawful medical termination of pregnancy during the policy period.

Medical Advice: means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

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.

Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

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

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

New Born Baby: means a baby born during the policy period and is aged between 1 day and 90 days, both days inclusive.

Network Provider: means hospital enlisted by an insurer, TPA, or jointly by a hospital and TPA to provide medical services to an insured by a cashless facility.

Non-Network: Any Hospital, day care centre or other provider that is not part of the Network

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

Out-Patient Treatment: is one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a

day care or in-patient.

Pre-Hospitalisation Expenses Medical Expenses: means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post-Hospitalisation Medical Expenses: means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital, provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Pre-Existing Disease (PED): Pre existing 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.
b. for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

Policy Period: means the period of coverage as mentioned in the schedule

Portability: means the right accorded to an individual health insurance Policy holder (including family cover), to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.

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.

Reasonable and Customary Charges: means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

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

Room Rent: means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Sum Insured - The maximum cover for a policy year, above the chosen Deductible, as opted by the Insured Person at the time of taking the Policy.

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 a day care centre by a Medical Practitioner.

Third Party Administrator (TPA): means any person who is registered under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016, notified by the Authority, and is engaged, for a fee or

remuneration by an insurance company, for the purposes of providing health services as defined in those regulations.

Unproven/Experimental Treatment: Treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

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 non-disclosure of any material fact.

4. EXCLUSIONS:

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

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 or its reinstatement.

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 or its reinstatement.

Specified disease / procedure waiting 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 ofthe continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b). incase 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.	12 months
ii	Polycystic ovarian diseases .	12 months
iii	Surgery of hernia.	24 months
iv	Surgery of hydrocele.	24 months
v	Non infective Arthritis.	24 months
vi	Undescendent Testes.	24 months
vii	Cataract.	24 months

viii	Surgery of benign prostatic hypertrophy.	24 months
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse	24 months
x	Fissure / Fistula in anus.	24 months
xi	Piles.	24 months
xii	Sinusitis and related disorders.	24 months
xiii	Surgery of gallbladder and bile duct excluding malignancy.	24 months
xiv	Surgery of genito urinary system excluding malignancy.	24 months
xv	Pilonidal Sinus.	24 months
xvi	Gout and Rheumatism.	24 months
xvii	Hypertension.	90 Days*
xviii	Diabetes.	90 Days*
	*Subject to application of clause 40 of policy conditions.	
xix	Calculus diseases.	24 months
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	24 months
xxi	Surgery of varicose veins and varicose ulcers.	24 months
xxii	Congenital internal diseases.	24 months
xxiii	Joint Replacement due to Degenerative condition.	48 months
xxiv	Age related osteoarthritis and Osteoporosis.	48 months

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 4.1., 4.2, 4.3 shall apply afresh, unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorized official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first Policy, clauses 4.1,4.2 and 4.3shall apply afresh on the enhanced portion of the Sum Insured.

30 day waiting period- code – ExcI 03

a). Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b). This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve mpnths.
c). The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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.

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

a) Expenes 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.

Obesity/Weight Control : Code- EscI 06
Expenses related to the surgical treatment of obesity that does not fulfill all the below 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.

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.

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 practioner.

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.

Breach of law – Code –ExcI 010
Expenses for treatment directly arising from or consequent upon any Insured Person commiting or attempting to commit a breach of law with criminal intent.

Excluded Providers- Code – ExcI 011
Expenses incurred towards treatment in any hospital or by any Medical Practioner 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 complete claim.

Treatment for, Alcolholic drug or substance abuse or any addictive condition and consequences thereof. – Code- ExcI01

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- Code- ExcI013

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 practioner as part of hospitalization claim or day care procedure.- Code- ExcI014

Refractive Error- Code- ExcI 015
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

Unproven Treatments- Code – excI 016

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.

Sterility and Infertility- Code- ExcI 017

Expenses related to sterility and infertility. This includes:

i). Any type of contraception, sterilization.

ii). Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.

Iii). Gestation Surrogacy. iv).

Reversal of sterilization.

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

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

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

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

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

Any expenses incurred on OPD treatment.

Treatment taken outside the geographical limits of India.

Pre and post hospitalization expenses unrelated with disease / injury for which hospitalization claim has been admitted under the policy.

5. **If the proposer/insured is suffering at the time of taking the policy or has suffered in the past, any of the diseases, enumerated as per serial no. 1 to 16 in the table given below, the same will be permanently excluded from the policy coverage:**

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9

2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C Malignant neoplasms of digestive organs, • C30-C39 Malignant ne of respiratory and intrathoracic organs• C40-C41 Malignant neopl bone and articular cartilage• C43-C44 Melanoma and other malign neoplasms of skin • C45-C49 Malignant neoplasms of mesothelia tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malig neoplasms of female genital organs • C60-C63 Malignant neoplas male genital organs • C64-C68 Malignant neoplasms of urinary tra C72 Malignant neoplasms of eye, brain and other parts of central n system • C73-C75 Malignant neoplasms of thyroid and other endo glands • C76-C80 Malignant neoplasms of ill-defined, other secon unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B Secondary neuroendocrine tumours • C81-C96 Malignant ne of lymphoid, hematopoietic and related tissue• D00-D09 In situ n • D10-D36 Benign neoplasms, except benign neuroendocrine tumo D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera myelodysplastic syndromes • D3A-D3A Benign neuroendocrine D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Conger disease and valvul disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart dis Q20 Congenital malformations of cardiac chambers and connectio Congenital malformations of cardiac septa • Q22 Congenital malfo of pulmonary and tricuspid valves • Q23 Congenital malformation aortic and mitral valves • Q24 Other congenital malformations of Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformatio peripheral vascular system• Q28 Other congenital malformations circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Ch rheumatic heart diseases Nonrheumatic mitral valve disorders mitr (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When unspecified cause but with mention of: • diseases of aortic valve (I mitral stenosis or obstruction (I05.0) when specified as congenital Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insu • Mitral (valve): incompetence / regurgitation - • NOS or of specif except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular dise
6	Inflammatory 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 diseas intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51. ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.

7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liv withfibrosis cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.- liver disease; Oesophageal varices in diseases classifiedelsewhere K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital cond pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney diseas	N17-N19) Renal failure; I12.0 - Hypertensive renal disease w failure; I12.9 Hypertensive renal disease without renal failure Hypertensive heart and renal disease with renal failure; I13.2 - Hyp heart and renal disease with both (congestive) heart failure and ren N99.0 - Post procedural renal failure; O08.4 - Renal failure abortion and ectopic and molar pregnancy; O90.4 - Postpartum a failure; P96.0 - Congenital renal failure. Congenital malformatio urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B withd (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with d (coinfection) without hepatic coma; B16.2 - Acute hepatitis B with agent with hepatic coma; B16.9 –Acute hepatitis B without delta- without hepatic coma; B17.0 –Acute (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepati delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified;F0 G30.9Dementia in Alzheimer's unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20 disease resulting in other bacterial infections; B20.2 - HIV disease in cytomegaloviral disease; B20.3 - HIV disease resulting in o infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HI resulting in other mycoses; B20.6 - HIV disease resulting in Pne carinii pneumonia; B20.7 - HIV disease resulting in multiple i B20.8 - HIV disease resulting in other infectious and parasitic B20.9 - HIV disease resulting in unspecified infectious or parasiti B23.0 - Acute HIV infection syndrome; B24 - Unspecifie immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hea unilateral with unrestricted hearing on the contralateral side; Conductive hearing loss, unspecified; H90.3 - Sensorineural hea bilateral; H90.4 - Sensorineural hearing loss, unilateral with un hearing on the contralateral side; H90.6 - Mixed conduc sensorineural hearing loss, bilateral; H90.7 - Mixed conduc sensorineural hearing loss, unilateral with unrestricted hearin contralateral side; H90.8 - Mixed conductive and sensorineural hea unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, un
15.	Papulosquamous disor skin	L40 - L45 Papulosquamous disorder of the skin including psoria

		Planus
16.	Avascular (osteonecrosis)	M 87 to M 87.9

If the above diseases are pre-existing at the time of inception, Exclusion no.4.1 for pre-existing disease shall be applicable, which means the above diseases will be covered only after the policy has been continuously in force for 48 months.

i **Note**: If continuity of renewal is not maintained then subsequent cover will be treated as fresh policy and clauses 4.1, 4.2 & 4.3 shall apply afresh (whether or not a Proposal is submitted afresh), unless agreed by the Company and suitable endorsement passed on the policy, by the duly authorised official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first policy, the exclusions 4.1, 4.2 and 4.3 will apply afresh on the enhanced portion of the Sum Insured.

ii Ported policy shall also be considered as continuous policy for the purpose of clauses 4.1, 4.2 & 4.3.

6. CONDITIONS:

1. ENTIRE CONTRACT: This policy, proposal form and declaration given by the insured constitute the complete contract.

2. DUE 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.

3. MATERIAL FACTS: The proposer is required to declare all material facts in the Proposal Form / any other document. Any misrepresentation or concealment of material facts shall render the policy void ab initio. A material fact is one which can influence the insurer's judgement to accept or reject the Proposal or the terms of acceptance

4. ENTRY AGE: Maximum entry age under the policy is 65years for all members. Persons above the age of 65 years and upto 70 years can also be covered. However, in such cases, a 10% loading will be charged on premium applicable to the age of such proposed insured. This 10% loading will also apply on each subsequent renewal thereof.

5. FAMILY SIZE: Minimum two persons (falling within the definition at 3.12) to be covered under the Family Floater plan (One single member can only be covered under Individual Plan). There is no cap on the number of family members in any of the Plans, as long as the definition of Family as given in 3.12 is fulfilled.

6. PLANS: Policy has Two Plans - **Individual and Family Floater** with following Sums Insured and corresponding Deductibles.
Option is also available to remove the Room rent limits by paying an additional premium:

Sl.No.	Deductible (INR)	Sum Insured (INR)
1	300000	300000
2	300000	500000
3	500000	500000
4	500000	700000
5	600000	600000

6	600000	800000
7	800000	800000
8	800000	1000000
9	1000000	1000000
10	1000000	1500000
11	1500000	1000000
12	1500000	1500000
13	1800000	1000000
14	1800000	1200000
15	2000000	1000000
16	2000000	2000000
17	2000000	3000000

7. **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. Advance premium payment shall be condition precedent to the contract.

8. **PREMIUM LOADINGS / DISCOUNTS**

a **FAMILY DISCOUNT:** of 10% is available if more than one is person is covered under the policy with individual Sums Insured per person (i.e in respect of an Individual plan).

b **LOYALTY DISCOUNT:** of 10% in premium is available for the persons who at the inception of this policy are also covered under a base health insurance policy from Oriental (retail or bancassurance only). To be eligible for this discount at renewals, such base health policy from Oriental has to be in force at the time of such renewal also. Even in case of Family Floater Plan, Loyalty discount would only be in respect of the person(s) who already has such a policy from Oriental and not on the whole policy premium.

c **STAFF DISCOUNT:** of 33% on premium is available to the employees (serving or retired) of Oriental Insurance Company Ltd. However, No commission and no other discount (except Portal discount, if applicable) like family discount, loyalty discount is allowed, where the Staff discount is availed.

d **PORTAL DISCOUNT: 10%** discount on premium, subject to maximum of Rs.2000, is available if the Policy is taken On-line using our Portal and where no intermediary is involved. This discount is applicable only when this policy is taken the first time, and is not allowed on renewals.

e **ENTRY AGE LOADING FOR PERSONS ABOVE THE AGE OF 65 YEARS:** Maximum entry age under the policy is 65years. However, persons above the age of 65 years and upto the age of 70 years can also take this policy, subject to a premium loading of 10%. So, in all such cases, a 10% loading will be charged on the premium applicable to the age of such proposed insured. This 10% loading will also apply on every subsequent renewal of the policy. No such loadings on renewal shall however, apply in respect of insured persons who had entered the policy at the age of 65years or earlier.

f **DELETION OF ROOM RENT LIMIT:** Room Rent limits are linked to the Deductible under the policy. However, on payment of an additional premium these limits can be removed. Additional premium shall be as per the loadings below:

Deductible (INR)	Additional Premium to be charged
Upto 5,00,000	20% of applicable premium
6,00,000- 10,00,000	10% of applicable premium
15,00,000 and above	5% of applicable premium

9A. 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.

9B. 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 etc.
VII) IV charges
VIII) Blood transfusion charges
IX) Dialysis
X) Surgery Charges
XI)OT charges including OT gas, equipment charges

9. PRE-INSURANCE MEDICAL CHECK-UP: In following cases, pre-insurance Medical Check- up is required:

Age	Pre-insurance Medical Tests
Persons with adverse Medical H	Required irrespective of age
Persons above 55years	Required in all cases

Following tests are required. The list of Diagnostic centres is available with the underwriting office from where the Policy is intended to be taken.

1	GENERAL PHYSICAL EXAMINATION
2	CBC WITH ESR
3	LIPID PROFILE
4	HbA1c
5	S.CREATININE
6	URINE-ROUTINE & MOLECULAR
7	ECG
8	TSH
9	X-RAY CHEST
10	USG
11	EYE EXAMINATION-FUNDUS & GLAUCO

- In case of adverse medical history, the Company may ask for additional tests depending on the medical condition.
- Medical reports up to 30 days prior to the date of proposal, are only valid.

- In case of fresh proposals where an insured person has undergone pre-insurance Medical Check up, 50% cost of Medical Check-up shall be reimbursed if the proposal has been accepted by the Company. Where there has been a break in the Policy Period and continuity benefits are not restored (i.e the Policy is treated as fresh and not as renewal), and the insured person has had to undergo such Medical Check up, in such cases also 50% cost of Medical Check-up shall be reimbursed.

10. FREE LOOK PERIOD:

The free look period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

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

If the insured has not made any claim during the free look period, the insured shall be entitled to

(i) A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons 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 policyholder, a deduction towards the proportionate risk premium for period on cover or

(iii). Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

11. 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 / TPA as shown in the Schedule. Updated list of the TPAs is also available on Company's website www.orientalinsurance.org.in.

12. MIDTERM INCLUSION: Midterm inclusion of members is permitted under the policy, on payment of pro-rata premium only on written request and only in respect of

a newly wed spouse within 90days of marriage or at the time of renewal of the policy.

b New Born / adopted Child from 91st day of birth / legal adoption or at the time of renewal of the Policy

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

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

I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give notice for renewal

II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years

III. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 day to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

V. No loading shall apply on renewal based on individual claims experience.

14. 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.

15. REVISION OF SUM INSURED / DEDUCTIBLE: Revision in Sum Insured under the Policy is allowed only at the time of Renewal based on the medical condition of the insured person(s) and claims experience under the policy. However, lowering of Deductible is not allowed in respect of any insured person, though one may increase the Deductible at renewal

16. 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.

17. NOTIFICATION OF CLAIM: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of Insured Person in respect of whom claim is made, Nature of disease / injury and Name and Address of the attending Medical Practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home, by fax, e-mail, etc. Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, in case of both planned and emergency hospitalization. Condonation of delay may be considered in cases of hardship where it is proved to the satisfaction of the Company TPA that under the circumstances in which the Insured Person was placed it was not possible for him or any other person to give such notice within the prescribed time limit.

18. Condition precedent to admission of liability: The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

19. 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 whom the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this policy or the Company's liability there under.

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 there under.

c Any Medical Practitioner authorised by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the Company / TPA.

20. PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME:

a Claim in respect of Cashless Services will be through the Company / TPA provided admission is in a network Hospital / Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorisation letter, within 48 hours of receipt of such a request, to the Hospital / Nursing Home mentioning the payable sum and the ailment for which the person is seeking to be admitted as an in-patient. The Company / TPA reserves the right to deny pre-authorisation in case the Hospital / Insured Person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless should in no way be construed as denial of liability. The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home for consideration of claim by the Company / TPA.

b 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 shall be given to the treating Hospital and the insured.

c Liability under the policy in respect of all expenses incurred in a Network Provider shall be subject to the pre-agreed rates between the Company/TPA and the Network Provider. This is irrespective of the claim being under

cashless or re-imbursement

d List of network Hospitals is available on our official website-www.orientalinsurance.org.in and will also be provided to the insured by the concerned TPA.

21. REIMBURSEMENT OF EXPENSES IN CASE OF TREATMENT IN NON-NETWORK HOSPITAL: The Insured Person can take treatment in non-network hospitals. In such a case, he should contact the TPA within 7 days from the date of admission with details of ID card number, nature of illness, name and address of the hospital/Nursing home. The Insured Person must fill the Claim Form and submit the documents required, in original for re-imbursement of the claim.

22. QUALITY OF TREATMENT: The insured hereby acknowledges and agrees that pre-authorisation 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).

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

a. Original bills, all receipts and discharge certificate / card from the hospital.
b. All documents pertaining to the illness, starting from the date it was first detected, i.e Doctor's consultations reports / history
c. Medical history of the patient recorded by the Hospital.
d. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
e. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by a note from attending medical practitioner / surgeon demanding such tests.
f. Original attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bills / receipts etc.
g. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
h. MLC/FIR/Post Mortem Report,(if applicable)
i. Document in respect of Organ donation by the insured person: a certificate from the concerned hospital that the organ donation is in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. However, no proof of expenses incurred is required.
j. Original Bills with supporting documents to the TPA for reimbursement of expenses incurred during pre and post hospitalisation.
k. Any other information required by Company / TPA.

NOTE:

- This policy would trigger only when the admissible expenses incurred (in respect of a single claim or in aggregate if more than one claim) has exceeded the Deductible. The Company would, therefore, require all previous proofs of hospitalization and expenses incurred to check if the Deductible under the policy has exceeded. So, the Insured is required to safely keep with himself all the treatment papers & bills & receipts in respect of previous Hospitalization(s) during the policy period. The insured may please refer sub-clause 5 (21) above, for the list of Claim documents in this regard.
- All documents must be submitted in original and duly attested by the Insured Person/Claimant. If the original documents have already been submitted elsewhere, photocopies of the same duly attested by the concerned TPA / Insurer / Organisation, as the case may be, and counter signed by the Insured, are required to be submitted.
- In case of post hospitalisation treatment under this Policy (limited to 60 days) all supporting claim papers / documents as listed above should be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. In addition Insured Person should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim. Waiver of this condition may be considered in cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured Person was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

i. DOCUMENTS IN CASE A SINGLE CLAIM HAS EXCEEDED / IS LIKELY TO EXCEED THE DEDUCTIBLE: All documents as listed above, are required to be submitted in respect of the claim under consideration.

ii. **DOCUMENTS IN CASE THERE ARE PREVIOUS CLAIMS IN THE SAME POLICY PERIOD:** If there are previous claims during the policy period, and a subsequent claim (after considering the aggregate of all previous claims) has exceeded / is likely to exceed the Deductible, then documents as listed above, would also be required for the previous claims in addition to those for the one under consideration.

iii. DOCUMENTS WHEN AN INDEMNITY HEALTH INSURANCE POLICY EXISTS AS BASE POLICY:

i. **When the TPA under this policy and the Base Policy is same**: If the TPA is same under both the policies and the documents have been submitted to the TPA, irrespective of the Insurer of the Base policy, the Insured may simply mention the Claim number allotted by the TPA, and submit the same alongwith the duly filled in Claim form.

ii. **When the TPA under this policy and the Base Policy is different:** If the TPA under both the policies are different, the Insured must submit the documents in respect of all the treatments taken during the policy period as given in the policy. If the original documents have already been submitted elsewhere, photocopies of the same duly attested by the concerned TPA / Insurer / Organisation, as the case may be, and counter signed by the Insured, are required to be submitted.

24. DISCLOSURE TO INFORMATION NORM: In case of Non-disclosure, concealment or mis- statement in the Proposal Form, Claim Form or any other document, or if the claim be in any manner- intentionally or fraudulently or otherwise misrepresented or concealed or involves making false statement or submitting false bills / documents whether by the Insured Person or any other person/ Institution/ Organisation on his behalf; Company shall be at liberty to deny its liability and / or take suitable legal action against such Insured Person/ Institution/ Organisation as per the laws.

25. MULTIPLE POLICIES:

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

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

iii. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the insured shall have the right to choose insurers from whom he wants to claim the balance amount.

iv. 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 hospitalisation costs in accordance with the terms and conditions of the chosen policy.

26. CLAIM SETTLEMENT (provision for Penal Interest):

i. 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.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. 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 ofclaim.

("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).

27. PAYMENT OF CLAIM: All medical treatments (including diagnostic tests) for the purpose of this insurance will have to be taken in India only (or in SAARC countries) and all claims shall be payable in Indian currency only. For the purpose of claim settlement in respect of treatment taken in SAARC countries, currency conversion rate on the date of admission to Hospital would apply.

Claim for any of the Insured Person will be payable in the name of the insured and discharge voucher signed by him/her will be considered valid. However, in the unfortunate event of demise of the insured, the claim shall be payable to the Nominee as declared by the insured in the Proposal form.

28. 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 guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurnace product/plan offered by the Company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

29. 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 rnewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any healt insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

30. 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 d 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/

31. ARBITRATION CLAUSE: 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 as amended from time to time.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein beforeprovided, if the Company has disputed or not accepted liability under or in respect of this policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

32. DISCLAIMER OF CLAIM: If the Company disclaims liability and communicates in writing to the Insured in respect of the claim 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.

33. 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.

34. Migration : "Migration" means, the right accorded to health insurance policy holders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

35. Portability: "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.

36. CANCELLATION CLAUSE:

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of

Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

b). The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of material facts fraud by the insured Person, by giving 30 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation non- disclosure of material facts or fraud.

37. CHANGE OF ADDRESS: Insured must inform the Company immediately in writing of any change in theaddress.

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

39. PRODUCT WITHDRAWAL: This product may be withdrawn in future with due approval of IRDAI. However, in the event of withdrawal of the product, the insured shall be informed of the options available.

40. 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 non-disclosure of any material fact by the policyholder.
("Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

41. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

42. MORATORIUM PERIOD

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

43. Complete Discharge

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

42. JURISDICTION: All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and according to the Indianlaws.

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

44. IT EXEMPTION: The premium under the Policy is eligible for Income Tax exemption in accordance with the extant IT Act.

Appendix I - Addresses of offices of Insurance Ombudsman

Areas of Jurisdiction	InsuranceOmbudsman, Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College,5, Navyug Colony, Ashram Road, Ahmedabad – 380014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 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@gbic.co.in
Madhya Pradesh and Chhat	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@gbic.co.in
Orissa	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Punjab , Haryana, Himachal Pr Jammu and Kashmir , UT of C	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
Tamil Nadu, UT–Pondicherry Karaikal (which are part o Pondicherry)	Office of the Insurance Ombudsman, Fatima Court, 4th Floor, 453, Anna Salai, Teynampet CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, U Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
	Office of the Insurance Ombudsman, Jeevan

Assam , Meghalaya, Manipur, Arunachal Pradesh, Nagaland a Tripura	Floor, Nr. Panbazar over bridge, S.S. Road, G 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
Andhra Pradesh, Karnataka an Yanam – a part of the UT of P	Office of the Insurance Ombudsman, 6-2-46, "Moin Court", Lane Opp. Saleem Function Pa A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 50 Tel.: 040 - 65504123 / 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@gbic.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in
Kerala , UT of (a) Lakshadwee Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Flo Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 6 Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in
West Bengal, UT of Andaman and Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bl Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Jalaun, Kanpur, Lucknow,Unnao, Sitapur, Lakhimpur, Bahraich,Barabanki Raebareli, Sravasti, Gonda, Faizab Amethi, Kaushambi, Balrampur, B Ambedkarnagar, Sultanpur, Mahar Santkabirnagar, Azamgarh, Kushi Gorkhpur, Deoria,Mau Ghazipur, Chandauli, Ball Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jee Bhawan, Phase-II, Nawal Kishor Road, Hazratgan Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in

Goa, Mumbai Metropolitan Region excl Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Je Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in

Appendix II

	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 the hard and soft palate
51	Excision and destruction of diseased hard and soft palate
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 haemorrhoids
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	Conisation of the uterine cervix
75	Incision of the uterus (hysterectomy)
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 prostatovesiculectomy
87	Incision and excision of periprostatic tissue
88	Operations on seminal vesicles
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