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**).

   1.1 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.

I	Insured Expenses	Limits of Insured Expenses
A	**HOSPITALISATION EXPENSES**	
i	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	1 % of the Deductible Amount (mentioned in the Policy Schedule) per day. *
ii.	Intensive Care Unit (**ICU**) expenses as provided by the Hospital /Nursing Home.	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. Expenses as specified in iii and iv below shall also be payable as per the entitled room rent limit as mentioned above. However, 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 prices (in case of network hospitals) shall be borne by the insured.	
iii.	Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees	within the limits of Sum Insured, subject to 'a' & 'b' above
iv.	Expenses in respect of Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial limbs and similar expenses.	within the limits of Sum Insured, subject to 'a' & 'b' above
v.	Organ Donor Benefit when Insured Person is Donor.	Lumpsum payment of 10% of the Sum Insured.
vi.	Donor Expenses when Insured Person is Recipient	within the limits of Sum Insured
vii.	Pre and Post hospitalisation expenses	Medical expenses incurred 30days prior to hospitalisation and upto 60 days post hospitalisation.

***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. In case of Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathic treatment, Hospitalisation expenses are admissible only when the treatment is taken as an in-patient.

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. 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.

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 the policy period. Hospitalisation expenses incurred is Rs.3lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.4lakhs	Scenario 1: Admissible expenses is Rs.2.50lakhs, which is within the Deductible so nothing is payable under the policy. Scenario 2: Admissible expenses is Rs.3.50lakhs, which has exceeded the Deductible by Rs.50,000, so the amount payable under the policy is Rs.50,000.
Case 2:	There are multiple claims under the policy. Claim no.1: Hospitalisation expenses incurred is Rs.2lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses –	Scenario 1: There are two claims under the policy, Claim Nos.1&2: Admissible expenses under Claim no.1 is Rs.2.lakhs and under Claim no.2, it is Rs.1.40lakhs. So the total admissible expenses under the policy considering both the claims is 3.40lakhs, which has exceeded the Deductible by Rs.40,000, so the amount payable under the policy is Rs.40,000 in respect of Claim no.2.

	Rs.3lakhs Claim no.2: Hospitalisation expenses incurred is Rs.1.75lakhs Pre & post hospitalisation expenses incurred is Rs.0.5lakh. Total incurred expenses – Rs.2.25lakhs	Scenario 2: The above is an example where Room rent is 1% of the Deductible. Now suppose, the insured's policy does not have room rent capping, then Admissible expenses under Claim no.1 is Rs.2.75lakhs and under Claim no.2 it is Rs.2lakhs. Thus the total admissible expenses under the policy considering both the claims, is 4.75lakhs, which has exceeded the Deductible by Rs.1.75lakhs, so the amount payable under the policy is Rs.1.75lakhs in respect of Claim no.2.
Case 3:	Claim no.1: This is the first hospitalisation in the policy period. Hospitalisation expenses incurred in respect of a pre-existing disease, is Rs.4.50lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.5.50lakhs Claim no.2: Hospitalisation expenses incurred is Rs.1.75lakhs. Pre & post hospitalisation expenses incurred is Rs.0.65lakhs. Total incurred expenses – Rs.2.40lakhs Claim no.3: Hospitalisation expenses incurred is Rs.1.75lakhs. Pre & post hospitalisation expenses incurred is Rs.0.75lakhs. Total incurred expenses – Rs.2.50lakhs	Scenario 1: Claim No.1 relates to pre-existing disease and is not admissible since it relates to Pre-existing disease. Claim No.2 has not exceeded the Deductible, hence nothing is payable, though the disease does not fall under any exclusion. In working out the payable amount for claim No.2, we will not consider Claim no.1 at all, since it falls under exclusion of pre-existing disease and is not admissible under the policy. It is of no concern whether or not the 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 under Claim no.3 it is Rs.2.20lakhs. Now the aggregate is Rs.4.30lakhs, which has exceeded the Deductible by Rs.1.30lakhs. So the amount payable under the policy is Rs.1.30lakhs in respect of Claim no.3. Scenario 2: The above is an example where Room rent is 1% of the Deductible. Now suppose, the insured's policy does not have room rent capping, then Admissible expenses under Claim no.2 is Rs.2.20lakhs and under Claim no.3 it is Rs.2.30lakhs. Thus the total admissible expenses under the policy considering both the claims, is 4.50lakhs, which has exceeded the Deductible by Rs.1.50lakhs, so the amount payable under the policy is Rs.1.50lakhs in respect of Claim no.3.
Case 4	There is one single hospitalisation in the policy	Admissible expenses is Rs.8.30 lakhs, which has exceeded the Deductible by Rs.5.30lakhs. Sum Insured

	period. Hospitalisation expenses incurred is Rs.8.50 lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.9.50lakhs	is Rs.5lakhs. So, the admissible expenses after considering the Deductible, is Rs.5.30lakhs, which is greater than the Sum Insured (Rs.5lakhs). However, the maximum admissible claim amount payable cannot exceed the Sum Insured under the policy. Hence amount payable in this case under the policy is Rs.5lakhs only and not Rs.5.30lakhs.
Case 5:	There is one single hospitalisation in the third policy (i.e in the second renewal) in respect of **donation of one kidney** by the insured to his father. Hospitalisation expenses incurred is Rs.0.45 lakhs. Pre & post hospitalisation Rs.1lakh. Total incurred expenses – Rs.1.45 lakhs	Since this relates to Organ Donor by the Insured Person, hospitalisation in respect of him, does not get paid. However, the policy would still pay him a lumpsum of 10% of the Sum Insured, as per clause 2A2 which would be Rs.50,000 in this case.

3. DEFINITIONS:

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

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

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

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

3.5 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.

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

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

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

3.8 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.

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

3.10 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.

3.11 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.

3.12 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.

3.13 Grace Period: means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity

benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

3.14 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 as under:

a. has qualified nursing staff under its employment round the clock;
b. has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient 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.

In case of AYUSH treatment, if the treatment is taken in a Government hospital or in any institute recognised by Govt. and/or accredited by Quality Council of India or National Accreditation Board on Health; **OR i**n

i. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian medicine (CCIM) and Central Council of Homeopathy (CCH)
ii. AYUSH hospitals having registration with Government authority under appropriate Act in the State / UT and complies with the following as minimum criteria

   a. has at least 15 inpatient beds
   b. has minimum 5 qualified and registered AYUSH doctors
   c. has qualified paramedical staff under its employment round the clock.
   d. has dedicated AYUSH therapy sections
   e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

3.15 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.

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

3.17 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

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

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

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

3.20 (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.

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

3.22 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.

3.23 Insured Person: means Person(s) named as Insured Person(s) on the schedule of the Policy.

3.24 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.

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

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

3.27 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.

3.28 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.

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

3.30 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.

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

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

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

3.34 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.

3.35 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.

3.36 Pre Existing Disease: means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice / treatment was

received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

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

3.38 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.

3.39 Qualified Nurse: means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

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

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

3.43 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.

3.44 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.

3.45 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.

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

3.47 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:

4.1 All Pre-existing Diseases (whether treated / untreated, declared or not declared in the Proposal Form), which are excluded upto 48 months of the Policy being in force and shall be covered only after the Policy has been continuously in force for 48 months.

This exclusion shall also apply to any complication(s) arising from pre-existing diseases.

4.2 Any disease other than those stated in clause 4.3 below, contracted by the Insured Person during the first 30 days from the inception date of fresh policy. This shall, however, not apply in case the Insured Person is hospitalised for injuries suffered in an accident, which occurred after inception of the policy.

4.3 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 of uterus.	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.	24 months
xviii	Diabetes.	24 months
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

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.

4.4 Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.

4.5 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination (including animal bite unless resulting in hospitalisation), inoculation or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.6 Surgery for correction of eye sight cost of spectacles, contact lenses, cochlear implant, hearing aids and other external aids / implants used for the correction of eyesight or of hearing prowess.

4.7 Any dental treatment or surgery which is corrective, cosmetic or aesthetic procedure, filling of cavity, crowns, root canal treatment including treatment for wear and tear unless arising from disease or injury and which requires hospitalisation for treatment.

4.8 Convalescence, general debility, "run down" condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders; diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction.

4.9 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases..

4.10 Expenses incurred at Hospital primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.

4.11 Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.

4.12 Any treatment (except as covered under 2A3) arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy. 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, do not fall under this exclusion clause.

4.13 Unproven and /or experimental procedure or treatment, acupressure, acupuncture, magnetic therapies.

4.14 Expenses for investigation/treatment irrelevant to the disease for which the insured person has been admitted or diagnosed. Private nursing charges, Referral fee to family doctors.

4.15 Stem cell implantation / surgery.

4.16 Cost of external and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, APDS, Infusion pump, Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps , splints, slings, braces, Stockings, of any kind, Diabetic foot wear, Glucometer / Thermometer, Blood Pressure monitoring machine and also any medical equipment which is subsequently used at home. Exhaustive list available in Appendix II.

4.17 All non-medical expenses, Personal comfort and convenience items or services, wi-fi/internet charges telephone, television, Ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items, guest services. Exhaustive list available in Appendix II.

4.18 Change of treatment from one system of medicine to another unless agreed / allowed and recommended by the Medical Practitioner / Consultant under whom the treatment is being taken.

4.19 Treatment for Age Related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

4.20 Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme.

4.21 Treatment in respect sleep apnoea and immuno-modulator drugs for cancer treatment.

4.22 Any treatment required because of Insured Person's participation in any hazardous activity including but not limited to aviation or ballooning, speed contests or racing on any kind(other than on foot), bungee jumping, parasailing, parachuting, ski-diving, BASE jumping, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, solo climbing, ice climbing, ice canoeing, scuba diving, Caving, cave diving, potholing, abseiling, snowboarding, wave-ski surfing, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and other hazardous activities or involving military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world.

4.23 Treatment taken in an Establishment which is a place for rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel, convalescent home, convalescent hospital, health hydro, nature care clinic.

4.24 Any stay in the hospital for any reason where no active regular treatment is given by the Medical Practitioner.

4.25 All Out-patient treatments including diagnostic, Medical or Surgical procedures, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.26 Massages, Steam bathing, Shirodhara under Ayurvedic treatment and all other external therapies which are not essential to the treatment of any disease.

4.27 Any kind of Service charges, Surcharges, Admission fees / Registration charges, RMO charges, levied by the hospital.

4.28 Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalisation period.

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

4.30 Hospital stay which is beyond regular, usual and customary limits for the treatment undertaken for the given disease / condition.

4.31 Any illness or injury arising or resulting from insured committing breach of Law with criminal intent

5. 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

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 History	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 & GLAUCOMA

- In case of adverse medical history, the Company may ask for additional tests depending on the medical condition.
- Medical reports upto 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: This policy provides for a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured is allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

If the Insured has not made any claim during the free look period, and exercises this option, the Insured shall be entitled to

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

b where the risk has already commenced and the option of return of the policy is exercised by the Insured, a deduction towards the proportionate risk premium for period on cover or

c where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

Premium on cancellation shall be refunded within 15days from the date of receipt of request for Free look cancellation.

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: Renewal of this Policy is not automatic; premium due must be paid to the Company on or before the due date. The Company shall not be responsible or liable for non-renewal of policy due to non-receipt **or** delayed receipt of premium **or** the proposal form **or** of the Medical Practitioner's report wherever required or due to any other reason within the control of the insured. Further, the Company shall not ordinarily deny the renewal of this policy unless on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured. No loadings based on claim(s) and / or age (except to the extent as provided for in clause 5 (8) (e) above) under the policy shall apply.

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If the policy is renewed for enhanced Sum Insured then clauses (4.1, 4.2, 4.3) as applicable to a fresh policy shall apply to additional Sum Insured as if a separate policy has been issued for the difference. In respect of Pre-existing Diseases or for a disease / ailment / injury for which treatment has been taken in the earlier policy period, the enhanced Sum Insured will be available only after 48 months of

continuous coverage with the increased Sum Insured. In case of addition of new members, the policy will be treated as fresh with respect to the newly added members.
No loading, on account of claims, will be levied on premium at the time of renewal.

14. **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

15. **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.

16. **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 hospitalisation. 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.

17. **MEDICAL RECORDS:**

a The Insured Person hereby agrees to and authorises 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.

18. **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 authorisation 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.

19. 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.

20. 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).

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

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.

a. **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.

b. **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.

c. 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.

22. 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.

23. **MULTIPLE POLICIES:** (a) In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar policies.

(b) If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the insured shall have the right to require a settlement of his claim in terms of any of his policies

i. In all such cases, the insurer who has issued the chosen policy, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. The insured having multiple policies has the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies even if the sum insured is not exhausted
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.

24. **PROTECTION OF POLICYHOLDERS' INTERESTS:** Company shall offer a settlement of claim to the insured / claimant (or convey repudiation, if a claim warrants so) within 30days of receipt of all necessary information / documents. Where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30days from the date of receipt of last necessary document. In such cases, the claim shall be decided within 45days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days the Company shall be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

25. **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.

26. **GRIEVANCE REDRESSAL:** When the Company repudiates a claim if not payable under the policy, the Company shall communicate the reasons for repudiation in writing to the Insured. In case of any grievance related to the policy or a claim thereunder, the Insured shall have the right to appeal / approach the Customer Service Department of the Company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road,

New Delhi-110002. E-mail id is csd@orientalinsurance.co.in. Exclusive e-mail id for grievance redressal of senior citizens is oiclhealthservice@orientalinsurance.co.in.
If the insured is not satisfied with the reply of the Customer Service department under above, he may register complaint with IRDAI at www.igms.irda.gov.in, or at 1800 4254 732; or approach Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.20 lacs. Region-wise list of Ombudsman offices is given at the end of this document.

27. 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 before provided, if the Company has disputed or not accepted liability under or in respect of this policy.
It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

28. 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.

29. REVISION IN PREMIUM / TERMS: The premium rates are valid only for the Policy period. The Company may revise the premium rates and / or the terms & conditions of the Policy, upon Renewal thereof, only after due approval from IRDAI. Any revision or modification in the Policy will be notified to the policyholders atleast ninety days prior to the date when such revision or modification comes into effect.

30. MIGRATION: At the time of renewal, or in the event of withdrawal of the product, the insured may migrate to another health insurance policy of the Company with all his continuity benefits remaining intact, provided there is no break in the policy

31. PORTABILITY: In the event of the Insured Person porting to any other insurer, Insured Person must apply with details of the policy and claims to the insurer where the Insured Person wants to port, atleast 45 days before the date of expiry of the policy.
If somebody wants to port into this policy, he has to apply within the above period. In case of acceptance of such request, Portability benefit shall be available only upto the existing Sum Insured. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, pre-existing clause and waiting periods shall separately apply on the Sum Insured in excess of the expiring Sum Insured.

32. CANCELLATION CLAUSE: Company may at any time cancel this Policy (on grounds of fraud, moral hazard, misrepresentation or non-co-operation), by sending the Insured 15(fifteen) days' notice by registered post at the Insured's last known address. No refund of premium shall be made in such

cases, except in case of cancellation on ground of non-co-operation, where refund shall be made on pro-rata basis.

The Insured may at any time cancel this policy and in such event the Company shall charge premium at Company's short period rate as per the table below and make refund, provided no claim has been reported during the policy period up to date of cancellation.

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

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

34. 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.

35. 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.

36. IRDAI REGULATIONS: This policy is subject to IRDAI (Protection of policy holders' interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations 2016 and Guidelines on Standardisation in health insurance, as amended from time to time.

37. JURISDICTION: All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and in accordance with the Indian laws.

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

List of Offices of Insurance Ombudsman

Areas of Jurisdiction	**Insurance Ombudsman, Office of the Insurance Ombudsman**
Gujarat , UT of Dadra and Nagar 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 Chhattisgarh	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
	Office of the Insurance Ombudsman, 62, Forest park,

Orissa	Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir , UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg.,

– a part of UT of Pondicherry	Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in

Appendix I

	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