THE ORIENTAL INSURANCE COMPANY LIMITED

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

PNB-ORIENTAL ROYAL MEDICLAIM – 2017 PROSPECTUS

1. ELIGIBILITY

a. **Maximum Entry Age is 79** years for all members.

b. Age will be **completed age** as on the date of commencement of the policy. Eg. if on a said date, the person is 79 years 364 days old, he will be considered as 79 years old for the purpose of coverage under thispolicy.

c. The Proposer has to be the Account holder at inception as well as on subsequentrenewals.

d. Any Account holder of Oriental Bank of Commerce (OBC), who is 18 years or more (but not exceeding 79 years), can take this Group Policy for self or for self and any one or more of the family members mentionedbelow:

i. Legally weddedspouse.

ii. Upto three Dependent Children (natural or legally adopted) between the ages of 91days to 18 years. However male child can be covered upto the age of 26 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughters are also eligible for coverage under the policy, irrespective of age. If during the currency of the policy, the child above 18 years becomes financially independent, or a male child (student) attains the age of 26 years or if the girl child gets married, he/she shall remain covered under the policy for the remainder of the policy period. However, he / she shall be ineligible for coverage in the subsequentrenewals.

e. Number of Policies that areallowed:

i. **One Account-One Policy**- (a) Only one policy can be issued on any oneAccount.
(b) In case of Joint Account holders, any one of the Account holders can be the proposer.

ii. **Multiple Accounts-One policy**- Only one policy can be issued even if the same person has more than one BankAccount.

iii. **One person One Policy**- One person can be covered only under one Bancassurance health insurance Policy of Oriental, whether he is the proposer or otherwise. However, there is no restriction on taking additional mainstream health insurance policies ofOriental.

If at any time an insured person is found to be covered under more than one Bancassurance policy of Oriental, flouting the above mentioned guidelines, all such policies, barring one (in case of a claim, the one under which claim is reported/considered), shall be cancelled and premium forfeited thereunder.

2. SALIENTFEATURES

i. This policy can be taken either for the self alone or alongwith the family (as specified in 1.0d above) with Sum Insured on floater basis.

ii. There are 10 Sum Insured slabs ranging from Rs.1lakhs to 10 lakhs, at an interval of 1lakh each.

iii. Pre-existing Diseases are covered after three consecutive Policyperiods.

iv. Premium is charged based on the age of the proposer Account holder and the Sum Insured opted.

v. No Pre-acceptance medical check-up is required. However, if the Proposal Form reveals adverse Medical History in respect of any proposed individual, such individual may be subject to pre-insurance

Medical tests. In such cases, 50% of the cost shall be borne by the Company, if the proposal in respect of that individual is accepted by theCompany.

vi. **Daily Hospital Cash** only in respect of the proposer Account holder: Rs.200 per day of hospitalisation is payable, maximum compensation being Rs.1000 during the policy period, subject to hospitalisation claim being admissible under thepolicy.

vii. **Organ donor expenses** when Insured Person is the Recipient: The policy covers In-patient Hospitalisation Medical expenses in respect of the organ donor provided that the organ donation is for the Insured Person and organ donation conforms to the Transplantation of Human Organs Act 1994(amended) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of humanorgans.

viii. **Ambulance Charges:** The policy covers ambulance charges upto Rs.1000 during the policy period, subject to claim in respect of hospitalisation being admissible under the policy.

ix. **Funeral Expenses**: Lumpsum amount of Rs.1000 per insured person is payable in case of death of the insured person, subject to hospitalisation claim being admissible under the policy.

x. 116 **Day Care Procedures**

xi. Term of the Policy is one year and is renewablelifelong.

xii. **Cashless facility** is available in networkhospitals

xiii. **Grace Period** of 30 days for renewal of policy, subject toconditions

xiv. **Free Look Period** of 15 days from the date of receipt of the policy documents.

xv. Sub-limits shall apply on following procedures, asbelow

		Sub-limits in INR		
Sl.	Procedure	SI < 2lakhs	SI 2-5 lakhs	SI >5lakhs
1.	Cataract	19000	24000	30000
2.	Total Knee Replacement excluding implant	90000	110000	150000
3.	Hip Replacement excluding implant	90000	110000	150000

Limits for 2&3 above are for unilateral procedures and additional 50% will be considered for bilateral procedures. Amount payable under the policy shall be the actuals (pre-negotiated rates in case of Network providers) or the above stated limits, whichever is lower.

3. COVERAGE

The policy covers reasonable and customary charges in respect of Hospitalisation and / or Domiciliary Hospitalisation for Medically Necessary treatment only for illnesses / diseases contracted/suffered or injury sustained by the Insured Person(s) during the Policy period, upto the limit of Sum Insured, as detailed below:

A.

Sl.	**Expenses covered**	**Limits**
i.	Room, Boarding and Nursing Expenses as provided by the Hospital /NursingHome.	1 % of the Sum Insured per day
ii	Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.	2% of the Sum Insured 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. All related expenses (including iii and iv below) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This restriction shall not apply on medicines / pharmaceuticals and bodyimplants. b. Any expense in excess of reasonable and customary charges as defined under 3.26, or in excess of negotiated prices (in case of network hospitals) shall be borne by the insured.	
iii	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of the Sum Insured.
iv	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis,Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & and similar expenses.	As per the limits of Sum Insured.
v	Ambulance service charges	Reimbursement upto maximum Rs.1000 in any Policy period, subject to claim being admissible under thehospitalization section of the policy
vi	Daily Hospital Cash Allowance – only in respect of the proposer Account holder.	Rs.200 per day of hospitalisation, maximum compensation being Rs.1000 during the policy period, subject to claim being admissible under the hospitalisation section of thepolicy.
vii	Funeral Expenses:	Lumpsum payment of Rs.1000 per Insured person in case of death of the insured person, subject to claim being admissible under thehospitalisation section of the policy
viii	Pre and Post Hospitalisation expenses	Medical expenses incurred
		30days prior to Hospitalisation and upto 60 days Post Hospitalisation.
B.	**DOMICILIARY HOSPITALISATION BENEFITS**	
i.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, DiagnosticMaterialand Dialysis, Chemotherapy, Nursing expenses.	10% of Sum Insured, Maximum Rs.25000/- during the Policy period.

Domiciliary Hospitalisation benefit shall, however, not cover expenses in any of the following cases

a) if the treatment lasts for a period of three days orless
b) incurred on treatment of any of the following diseases:
    i. Asthma
    ii. Bronchitis

iii. Chronic Nephritis and NephriticSyndrome
iv. Diarrhoea and all types of Dysenteries includingGastro-enteritis
v. Diabetes Mellitus andInsipidus
vi. Epilepsy
vii. Hypertension
viii. Influenza, Cough andCold
ix. Pyrexia of unknown origin for less than 10days
x. Tonsillitis and Upper Respiratory Tractinfection including Laryngitis and Pharyngitis
xi. Arthritis, Gout andRheumatism.

Note: (i) Liability of the Company under Domiciliary Hospitalisation Benefit is limited as stated in2B.
(ii) Maximum liability of the Company under the policy is the Sum Insured as stated in the schedule.

C. Relaxation to 24 hours minimum duration of hospitalisation is allowed in Specified Day Care procedures / Surgeries 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 any other Day Care Treatment as mentioned in clause 3.10 and for which prior approval from Company / TPA is obtained in writing.

D. Telemedicine- Expenses incurred by insured on telemedicine/Tele-consultation with a Registered medical practitioner for Diagnosis & treatment of a disease/illness covered under the Policy. Suchreasonableincurred 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/Sub limits prescribed in Policy Schedule. Telemedicine offered shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020 by MCI and as amended from time to time." The limit of amount payable for telemedicine is Maximum Rs. 2,000/- per insured &/or per family, for a policy period.

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

E. HIV/ AIDSCover

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

i. Acute HIV infection – acute flu-likesymptoms
ii. Clinical latency – usually asymptomatic or mildsymptoms
iii. AIDS – full-blown disease; CD4 <200

F. Mental Illness Cover:

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

1. Illness covered under definition of mental illness *.
2. Hospitalization in Mental Health Establishment as defined *.
3. Hospitalization as adc Mental Health Professional as defined *.
4. Mental Conditions associated with the abuse of alcohol and drugs areexcluded.
5. Mental Retardation and associated complications arising therein areexcluded.

6. Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not becovered.

*Please refer Definitions clause.

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

Name of the Procedure	Sub limits
A. Uterine Artery Embolization and HIFU	Per policy period: Up to INR 50,000.
B. Balloon Sinuplasty	Per policy period: Up to INR 40,000.
C. Deep Brain stimulation	Per policy period 10% of SI, subject to maximum INR 50,000.
D. Oral chemotherapy	Per policy period 25% of SI, subject to maximum INR 50,000.
E. Immunotherapy- Monoclonal Antibody to be given as injection	Per policy period 10% of SI, subject to maximum INR 50,000.
F. Intra vitreal injections	Per policy period 10% of SI, subject to maximum INR 50,000.
G. Robotic surgeries	Per Policy period 10% of SI, subject to maximum INR 1,00,000.
H. Stereotactic radio surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.
I. Bronchial Thermoplasty	Per policy period 10% of SI, subject to maximum INR 1,00,000.
J. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)	Per policy period 10% of SI, subject to maximum INR 50,000.
K. IONM - (Intra Operative Neuro Monitoring)	Per policy period 10% of SI, subject to maximum INR 50,000.
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant forhematological conditions to be covered.	Per policy period 10% of SI, subject to maximum INR 50,000.

4. DEFINITIONS:

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

Ambulance Services: means ambulance service charges reasonably and necessarily incurred in shifting the insured person from residence to hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the hospitalisation expenses are admissible under thepolicy.

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

Bancassurance: means an arrangement entered into by the Company, with one or more Banks, for selling, inter-alia, health insurancepolicies.

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 isapproved.

Daily Hospital Cash Allowance: When an insured account holder is hospitalized and a claim is admitted under the Policy, then the Company shall pay a Daily Hospital Cash Allowance as specified under 2A(vi) above.

DOMICILIARY HOSPITALISATION BENEFIT: means medical treatment for a period exceeding three days for such disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i. the medical condition of the patient is such that he/she is not in a position to be moved to a hospital, or
ii. the patient takes treatment at home on account of non availability of room in ahospital.

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 asunder:-

a. has qualified nursing staff under itsemployment,
b. has qualified medical practitioner (s) incharge,
c. has a fully equipped operation theatre of its own, where surgical procedures are carriedout
d. maintains daily records of patients and will make these accessible to the Insurance company's authorizedpersonnel.

Day Care Treatment: refers to medical treatment, and/or surgical procedure whichis:

a. undertaken under General or Local anaesthesia 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 24hours.

Procedures / treatments done in Out Patient Department are not payable under the policy even if

converted to day care surgery / procedure or as in patient in the hospital for more than 24 hours.

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 criteriaasunder:

a) hasqualifiednursingstaffunderitsemploymentroundtheclock;

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 otherplaces;

c) hasqualifiedMedical Practitioner(s)inchargeroundtheclock;

d) hasafullyequippedoperationtheatreofitsownwheresurgicalproceduresarecarriedout

e) MaintainsdailyrecordsofpatientsandmakestheseaccessibletotheInsuranceCompany'sauthorizedpersonnel.

*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, ifany:

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 UpcharyaGrihaTathaRujopcharSanbadhuSthapamaue (RagistrikaranTathaAnugyapan) 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 of Indian
Medicine/ Central Council for Homeopathy;or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practionerand must comply with all the followingcriterion:
i. Having at least five in- patientbeds;
ii. Having qualified AYUSH Medical Practionerin charge round theclock;
iii. HavingdedicatedAYUSHtherapysectionsasrequiredand/orhasequippedoperationtheatrewheresurgical procedures are to be carriedout;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

AYUSH Day CareCentre:

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

i. Having qualified registered AYUSH Medical Practitioner (s) incharge.

ii. HavingdedicatedAYUSHtherapysectionsasrequiredand/orhasequippedoperationtheatrewheresurgical procedures are to be carriedout;

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 consecutivehours.

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

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 medicaltreatment.

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 fullrecovery.

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 /ortests
   ii. it needs ongoing or long-term control or relief ofsymptoms
   iii. it requires rehabilitation or to be specially trained to cope withit
   iv. it continuesindefinitely
   v. it comes back or is likely to comeback.

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 MedicalPractitioner.

Insured Person: Means Person(s) named as Insured Person(s) on the schedule of thePolicy.

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 policyperiod.

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

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 medicaltreatment.

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

a. is required for the medical management of the illness or injury suffered by theinsured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, orintensity;

c. must have been prescribed by a medicalpractitioner;

d. must conform to the professional standards widely accepted in international medical practice or by the medical community inIndia.

Medical Practitioner: means a person who holds a valid registration fromthe 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 oflicense.

Network Provider: means hospital or health care provider enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured either on payment or by a cashlessfacility.

Pre-Hospitalisation Expenses: means medical expenses incurred duringtheperiod upto 30 days prior to the date of admission in the hospital providedthat:

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 InsuranceCompany.

Post-Hospitalisation Expenses: means medical expenses incurred for a period upto 60 days from the date of discharge from the hospital, providedthat:

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 theInsuranceCompany.

Pre-Existing Disease (PED): Pre existing disease means any condition, ailment, injury ordisease:

a.that is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer,or itsreinstatement.

or which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or itsreinstatement.

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 / injuryinvolved.

Renewal: Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all

waitingperiods.

Third Party Administrator (TPA): means any person who is licensed 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 thoseregulations.

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

Unproven/Experimental Treatment: Treatment including drug experimental therapy which is not based on established medical practice inIndia.

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.

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 andtimebound exclusions, with the sameinsurer.

Mental Illness: "mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not includementalretardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

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

Mental health professional:

i a psychiatristor

ii a professional registered with the concerned State Authority under section 55;or

iii a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvumManasRoga or a post- graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post- graduate degree (Siddha) in SirappuMaruthuvam;

5.EXCLUSIONS: Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

Pre-existing Diseases-code–ExcI01

a). Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 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 36 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/procedurewaitingperiod-code-ExcI02

a). Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of the specified waiting period of the continuous coverage after the date of inception of the first policy with us.
This exclusion shall not be applicable for claims arising due to an accident.
b). in case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. c). If any of the specified disease/ procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d). the waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e). If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage. f). The expenses on treatment of following ailments / diseases / surgeries, if contracted and /or manifested after inception of first Policy(subject to continuity being maintained), are not payable during the waiting period specified below:

Sl.no.	Ailment / Disease / Surgery	Waiting Period
I	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy,Tympanoplasty etc.	**1** year
Ii	Polycystic ovarian diseases.	**1** year
Iii	Surgery of hernia.	**2** years
Iv	Surgery of hydrocele.	**2** years
V	Non infective Arthritis.	**2** years
Vi	Undescendent Testes.	**2** Years
Vii	Cataract.	**2** Years
Viii	Surgery of benign prostatic hypertrophy.	**2** Years
Ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	**2** Years
X	Fissure / Fistula in anus.	**2** Years
Xi	Piles.	**2** Years
Xii	Sinusitis and related disorders.	**2** Years
Xiii	Surgery of gallbladder and bile duct excluding malignancy.	**2** Years
Xiv	Surgery of genito-urinary system excluding malignancy.	**2** Years
Xv	Pilonidal Sinus.	**2** Years
Xvi	Gout and Rheumatism.	**2** Years
Xvii	Hypertension.	**90 days***
Xviii	Diabetes.	**90 days***
	*Subject to application of the policy condition- 'Disclosure of Information’	

Xix	Calculus diseases.	**2** Years
Xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	**2** Years
Xxi	Surgery of varicose veins and varicose ulcers.	**2** Years
Xxii	Congenital internal diseases.	**2** Years
Xxiii	Joint Replacement due to Degenerative condition.	**3**Years
Xxiv	Age related osteoarthritis and Osteoporosis.	**3**Years

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

30 day waiting period- code – ExcI03

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

GENERAL EXCLUSIONS: The Company shall not be liable to make any payment under this Policy in respect ofanyexpensewhatsoever incurredbyanyInsuredPersoninconnectionwithorinrespectof:

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 –ExcI05

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such a bathing, dressing, moving around either by skilled nurses or assistant or non-skilledpersons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritualneeds.

Obesity/Weight Control : Code- EscI06

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 40or

b). greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failures of less invasive methods of weightloss:
i). Obesity – related cardiomyopathy
ii). Coronary heart diseases
iii).Severe SleepApnea.
iv).Uncontrolled Type 2Diabetes.

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

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

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

Breach of law – Code –ExcI010
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, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – Code- Excl 0I2

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- ExcI015
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- ExcI017
Expenses related to sterility and infertility. This includes: i). Any type of contraception, sterilization.
ii). Assisted Reproduction services including artificial inseminationandadvanced reproductive

technologies
such as IVF, ZIFT, GIFT,ICSI.
Iii). Gestation Surrogacy. iv). Reversal ofsterilization.

Maternity- Code- ExcI018
i). Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization) except ectopicpregnancy.
ii). Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policyperiod.

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 ordeath.

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 ordeath.

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 ordeath.

Any expenses incurred on OPD treatment

Treatment taken outside the geographical limits of India.

6. If the proposer is suffering or has suffered from any of the following disease, as per serial no. 1- 16 of the below table at the time of taking the policy, the specific ICD codes will be permanently excluded from the policycoverage:

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

2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64- C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertainbehaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS orof specified cause, except rheumatic, I 34.1to I34.9 - Valvular heartdisease.
5	Cerebrovascular disease(Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.

7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis andcirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophagealvarices in diseases classifiedelsewhere. K 70 to K74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent(coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta- agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified

15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

7. CONDITIONS

Payment of Premium: The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium shall be condition precedent to the contract.

Due Observance: Observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this Policy shall be valid, unless made in writing and signed by an authorised official of theCompany.

A. Midterm inclusion: Midterm inclusion of members under the Policy is permitted only on written request and only in respectof

i. Newly wed spouse, within 90days of marriage or at the time of renewal of thePolicy.
ii. New Born / adopted Child from 91st day of birth / legal adoption or at the time of renewal of thePolicy.

B. Enhancement of Sum Insured: Increase in Sum Insured under the Policy is allowed only at the time of Renewal. Increase shall be as given below:

i. On Renewal, Sum Insured can be increased to the immediate higherslab.
ii. If size of the family increases on Renewal, Sum Insured can be increased to maximum two slabshigher.
iii. If there are no claims reported in the two immediate preceding Policy Periods, increase upto any available Sum Insured isallowed.
iv. Notwithstanding above provisions, no increase in Sum Insured is allowed inpolicies
a. where there are claims reported consecutively in the two immediate preceding Policy Periods OR
b. where any one of the insured persons is above the age of 80years.

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 thepolicy.

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 premiumfor 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.

Portability: This policy is portable to the extent that the insured member may opt out of the group and switch from group insurance plan to Individual/Family insurance cover with the same insurer (the group insurer).

Portability maintains the credit gained by the insured for Pre-existing conditions and time bound exclusions.

Portability under this policy shall be allowed as per clause(1) of chapter VIII of Consolidated Guidelines on Migration and Portability of Health insurance and in accordance to the norms specified under IRDAI (Health Insurance) Regulations, 2016.

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

Notice of claim: Immediate written notice of claim with particulars relating to Policy number, ID Card no., Name of insured person in respect of whom claim is made, nature of disease / illness / 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, email. Such written notice should be given within 48 (forty eight) hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier unless waived in writing.

Procedure for availing cashless access services in network hospital/nursinghome:

i. Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital / Nursing Home and is subject to pre admission authorization.
ii. The Company / TPA reserves the right to deny pre-authorization in case the Hospital / Insured Person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability.
iii. 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.
iv. 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 orre-imbursement.

Claim Documents: Final claim along with documents stated in the policy, should be submitted to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home.

PROPORTIONATE CLAUSE–

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

B. ASSOCIATED MEDICAL EXPENSES:

- Doctor’s fees / Consultant fees/RMOfees
- Nursing expenses including administration charges/ transfusion charges/ injectioncharges
- Surgeon fees / Asst Surgeon fees Anesthesiafees

Procedure charges of any kind which includes :-

Chemotherapy/Radiotherapy charges
Nebulisation
Hemodialysis
PICC lineinsertion
Catheterisationcharges Tracheostomyetc.
IV charges
Blood transfusion charges

Dialysis
Surgery Charges
OT charges including OT gas, equipment charges.

Disclosure of Information: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(**Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)**

Payment of Claim: All medical treatments (including diagnostic tests) for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only.

CLAIM SETTLEMENT (provision for PenalInterest):

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 thecaseofdelayinthepaymentofaclaim,the Companyshallbeliabletopayinteresttothepolicyholderfromthe dateofreceiptoflastnecessarydocument tothedateofpaymentofclaimatarate2%abovethebankrate.
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 necessarydocument.
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 financialyear in which claim has fallen due).

Contribution: 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 hispolicies
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. Claim under other policy/policies can be made after exhaustion of the sum insured in the earlier chosen policy/policies. However, the insured shall also have the right to prefer claim from other policy/policies for the amounts disallowed under the earlier chosen policy/policies even if the sum insured is notexhausted.

Renewal ofPolicy:
i. The policy shall ordinarily be renewable except on grounds of fraud, Misrepresentation by the insuredperson.
a. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
b. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
c. The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reasonwhatsoever.
d. Not withstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium rates and / or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic;
e. Premium due must be paid by the proposer to the company before the duedate.

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

Grace period: In the event of delay in renewal of the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease under the renewedpolicy.

POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUMRATES:

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.

GrievanceRedressal:

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
AliRoad,
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/

Arbitration: 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 underandin accordance with the provisions of the Arbitration and Conciliation Act, 1996, and subsequent amendments.

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 thispolicy.

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.

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

PeriodonRisk	Rate of premium to becharged
Up to1Month	1/4th of the annualrate
Up to3Months	1/2 of the annualrate
Up to6Months	3/4th of the annualrate
Exceeding6months	Full annualrate

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 (thirty) days' written notice.

Also, anytime during the currency of the policy, if violation of Condition no. 9(viii) (kindly refer to policy condition) comes to the notice, the Company shall cancel all policies, but one, choice of such one policy shall be with the affected Account holder.

There would be no refund of premium shall be made when cancellation is on grounds of fraud, moral hazard or misrepresentation or violation of Condition no. 9 (viii) (kindly refer to policy condition).

Withdrawal ofPolicy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured person about the same 90 days prior to expiry of thepolicy.

ii. Insured person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without abreak.

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.

MORATORIUMPERIOD

After completion of eight continuous years under this policy no look back to be applied. This period ofeight 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.

IT Exemption: The premium under the Policy is eligible for Income Tax exemption in accordance with the extant ITAct.

IRDAI Regulations: This Policy is subject to IRDAI (Protection of policy holders' interest) Regulation, 2002 & 2017 and IRDAI (Health Insurance) Regulations 2013 & 2016 and Guidelines on Standardisation in Health Insurance as amended from time totime.

Jurisdiction: All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and according to the IndianLaws.

How to apply for Insurance: The Proposer has to complete the Proposal Form in duplicate and submit Insured Person's details in respect of each member. The proposer has to affix coloured stamp size photograph of each member proposed to be insured on the Proposal Form against the name of the person. These photographs will be utilised by TPA for preparing IDcards.

The Prospectus contains salient features of the Policy. For details, reference is to be made to the Policy. In case of any difference between the Prospectus and the Policy, the terms and conditions of the Policy shallprevail.

The Prospectus and Proposal Form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal Form is to be completed in all respects for each person proposed for insurance. Both the Prospectus and the Proposal Form are to be submitted to the office or to theagent.

Name oftheProposer: Signature

Address:

Place: Date:

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OFREBATE

Section 41 of the Insurance Act 1938 provides as follows:

1. No person shall allow, or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate except such rebate as may be allowed in accordance with the published Prospectus or tables of theInsurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty

which may extend to INR Ten Lakhs.

PremiumChart:

Current Premium			
SI/Age Band	**18-40**	**41-60**	**Above 60**
100000	2,637	2,704	5,427
200000	4,628	4,699	9,215
300000	6,410	6,458	12,560
400000	7,709	7,875	15,647
500000	8,813	9,104	17,429
600000	10,673	11,669	20,788
700000	11,559	12,600	22,126
800000	12,386	12,863	23,284
900000	13,165	13,398	24,305
1000000	13,902	14,730	25,219

a. Premium is in Indian Rupees
b. Premium to be charged based on the age of the proposer Accountholder
c. Taxes as applicable shall be extra
d. Above premium is upto a family of five members