



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

HAPPY FAMILY FLOATER POLICY – 2015
WE VALUE YOUR HEALTH & YOUR WEALTH...BUILD A PRODUCTIVE NATION

1.1 WHEREAS the insured named in the Schedule hereto has by a proposal and declaration (which shall be the basis of this Contract and is deemed to be incorporated herein) has applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the Company) for the insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (hereinafter called the INSURED PERSON (S)) and has paid premium to the Company as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the TPA) or the Company as the case may be.

Now this Policy witnesses that 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) shall contract or suffer from any Illness / ailment / disease (hereinafter called 'DISEASE') or sustain 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 (a) Hospitalisation (as defined hereinafter) for medical/surgical treatment at any Nursing Home/Hospital in **India** as herein defined (hereinafter called 'HOSPITAL') as an In-patient **OR** (b) on Domiciliary treatment in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company / TPA 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 upto the limit specified in the Policy and/or schedule of the Policy, but not exceeding the Sum Insured as stated in the schedule, for all claims arising during the Policy Period mentioned in the schedule

1.2 COVERAGE - The benefits under this Policy are available under three plans, viz **Silver, Gold & Diamond** as opted by the Insured in the proposal form.

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:

Sl. No	Expenses covered	SILVER Limits of covered Expenses	GOLD Limits of covered Expenses	DIAMOND Limits of covered Expenses
A.	HOSPITALISATION BENEFITS			
i.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	1 % of the Sum Insured per day	1 % of the Sum Insured per day.	Rs.10,000 + 0.5% of the Sum Insured above Rs.10lacs, per day
ii	Intensive Care Unit(ICU) Expenses as provided by the Hospital /Nursing Home.	2% of the Sum Insured per day.	2% of the Sum Insured per day.	Rs.20,000 + 1% of the Sum Insured above Rs.10lacs, per day
	Number of days of stay under 'i' and 'ii' above should not exceed total number of days of admission 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 will not apply on medicines / pharmaceuticals and body implants.			
iii.	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of Sum Insured .	As per the limits of Sum Insured.	As per the limits of 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 .	As per the limits of Sum Insured.	As per the limits of Sum Insured.
v.	Ambulance service charges as hereinafter defined.	<ul style="list-style-type: none"> • Per Illness -Rs.1000 maximum. • Per Policy Period-1% of Sum Insured, subject to maximum Rs.3000. 	<ul style="list-style-type: none"> • Per Illness - Rs.2000 maximum. • Per Policy Period- Rs.6000 maximum. 	<ul style="list-style-type: none"> • Per Illness - Rs.3000 maximum. • Per Policy Period- Rs.8000 maximum.
vi.	Daily Hospital Cash Allowance as hereinafter defined.	Not Available	0.1% of Sum Insured (Rs.600 to RS.1000) per day of Hospitalisation, subject to a maximum compensation for 10 days per Illness. Overall liability of the Company during the Policy Period will be limited to 1.5% of	0.1% of Sum Insured (Rs.1200 to Rs.2000) per day of Hospitalisation, subject to a maximum compensation for 10 days per Illness. Overall liability of the Company during the Policy Period will be limited to 1.5% of

			the Sum Insured.	the Sum Insured.
vii.	Attendant allowance as hereinafter defined.	Not Available	Rs.500/- per day of Hospitalisation, subject to maximum compensation for 10 days per Illness. Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalisation. .	Rs.1000/- per day of Hospitalisation, subject to maximum compensation for 10 days per Illness. Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalisation.
viii	Maternity expenses as hereinafter defined	Not Available	Not Available	Automatic cover upto 2.5% of the Sum Insured.
ix	New Born Baby cover as hereinafter defined.	Not Available	Not Available	Automatic cover upto 2.5% of the Sum Insured upto 90days from the date of birth. Cover beyond 90 days, available for full Sum Insured only on payment of requisite premium.
x.	Medical Second Opinion on specified major Illnesses.	Maximum Rs.5000 in a Policy Period.	Maximum Rs.10,000 in a Policy Period	Maximum Rs.15,000 in a Policy Period
xi.	Organ Donor Benefit when Insured Person is Donor.	Lumpsum payment of 10% of the Sum Insured.	Lumpsum payment of 10% of the Sum Insured.	Lumpsum payment of 10% of the Sum Insured.
xii	Donor Expenses when Insured Person is Recipient	As per the limits of Sum Insured	As per the limits of Sum Insured	As per the limits of Sum Insured
xiii	Pre and Post Hospitalisation expenses	Medical expenses incurred 30days prior to Hospitalisation and upto 60 days post Hospitalisation.		
xiv	Compulsory co-payment	10% of each & every claim	Not Applicable	Not Applicable
	<p>Note:1. In case of Ayurvedic /Siddha/ Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as an in-patient, in a Government Hospital or in any Institute recognised by Govt. and/or accredited by Quality Council of India / National Accreditation Board on Health.</p> <p>2. Relaxation to 24 hours minimum duration for Hospitalization is allowed in a Day care procedures / surgeries (Appendix I) where such treatment is taken by an Insured Person in a Hospital / day care centre (but not the Out-patient department of a Hospital), Or b Any other day care treatment as mentioned in clause 3.11 and for which prior approval from Company / TPA is obtained in writing.</p>			

B. DOMICILIARY HOSPITALISATION BENEFITS				
i.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	10% of Sum Insured, Maximum Rs.25000/- during the Policy Period.	Maximum Rs.50000/- during the Policy Period.	Maximum Rs.50000 during the Policy Period.
ii.	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)	Maximum Rs.5,000/- actually incurred on immunisation injections in any one Policy Period. This will be part of Domiciliary Hospitalisation limits as specified. For the purpose of this clause the conditions for Domiciliary Hospitalisation benefit shall not apply.		

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 or less
- b) incurred on Pre and Post Hospitalisation treatment and
- c) incurred on treatment of any of the following diseases :
 - i. Asthma
 - ii. Bronchitis
 - iii. Chronic Nephritis and Nephritic Syndrome
 - iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis
 - v. Diabetes Mellitus and Insipidus
 - vi. Epilepsy
 - vii. Hypertension
 - viii. Influenza, Cough and Cold
 - ix. All Psychiatric or Psychosomatic Disorders
 - x. Pyrexia of unknown origin for less than 10 days
 - xi. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis
 - xii. Arthritis, Gout and Rheumatism.

Note: Liability of the Company under Domiciliary Hospitalisation Benefit is restricted as stated in 1.2B.

1.3 DAILY HOSPITAL CASH ALLOWANCE: When an Insured Person is Hospitalised and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period of 24 hours of Hospitalisation, as mentioned under 1.2 A (vi) above.

1.4 ATTENDANT ALLOWANCE: When an Insured Person above the age of 90days and upto the age of 10 years is Hospitalized and a claim is admitted under the GOLD or DIAMOND plan of the Policy, a sum as mentioned under 1.2A (vii) above will become payable under the Policy.

1.5. MATERNITY EXPENSES AND NEW BORN BABY COVER UNDER DIAMOND PLAN

- A. MATERNITY EXPENSES:** The Company shall pay the Medical Expenses incurred as an In-patient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person. This benefit is applicable only in Diamond Plan, and available only to the Insured or his spouse, provided that:
- i. Diamond Plan has been continuously in force for a period of minimum 24 months in respect of both the Insured and his/her spouse.
 - ii. Those Insured Persons who are already having two or more living children will not be eligible for this benefit
 - iii. Company's maximum liability per delivery or termination shall be limited to 2.5% of the Sum Insured as stated in the Schedule and in no case shall the Company's liability under this clause exceed 2.5% of the Sum Insured, in any one Policy Period.
- B. NEW BORN BABY COVER:** New born Baby shall be covered from day one upto the age of 90days and expenses incurred for treatment taken in Hospital as in patient shall only be payable, provided that:
- i. Claim under Maternity clause is admissible under the Policy
 - ii. Company's liability shall be limited to 2.5% of the Sum Insured as stated in the Schedule.
 - iii. 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 2.5% of the Sum Insured of the Policy under which Maternity claim was admitted.

Special conditions applicable to Maternity Expenses and New Born Baby Cover

- i. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Home as in-patients in India.
- ii. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
- iii. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.
- iv. Pre Hospitalisation and Post Hospitalisation benefits are not available under these two clauses.
- v. Subject to the terms & conditions, the Policy covers New Born Baby beyond 90 days only on payment of requisite premium.

1.6 MEDICAL SECOND OPINION - If the Insured Person is diagnosed with one of the specified major Illnesses listed below, and takes Medical Second Opinion (including opinion obtained from overseas) whether before starting the treatment or during the course of treatment, the Policy covers Medical Expert's fees to the extent given in clause 1.2 above. Claim under this clause would be admissible subject to the Hospitalisation claim being admissible. This expense is payable only once per Illness per Insured Person during the life time of the Insured Person.

Major Illnesses covered:

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

1.7 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(amended) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs.

This benefit is subject to the Policy (Happy Family Floater Policy-2015) having been continuously in force for atleast 12 (twelve) months in respect of that Insured Person.

1.8 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 donation conforms to the Transplantation of Human Organs Act 1994(amended) 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) cost directly or indirectly associated with the acquisition of the organ and/or cost of organ.
- b) cost towards donor screening
- c) Any Pre and Post Hospitalisation medical expenses of the donor.
- d) Any other medical treatment or complication consequent to organ harvesting, in respect of the donor.

Company's overall Liability in respect of all claims admitted under clause 1.2 during the Policy Period shall not exceed the Sum Insured mentioned in the Schedule.

2. OPTIONAL COVERS

2.A GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES: The Policy can be extended to cover Insured Persons visiting other SAARC (South Asian Association for Regional Co-operation) countries -Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka. No additional premium will be charged for this extension. However, the Insured Person has to make a request for

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such extension, in writing, before leaving the country, duly informing the duration, purpose and country(ies) of visit. Endorsement for such extension will be issued by the Company.

It is further stated that Cashless service will not be available for treatment taken in countries outside India and such claims, shall be considered only on re-imburement basis.

2.B Following coverages can be taken on payment of additional premium.

Sl.no	Features / Plans	SILVER	GOLD	DIAMOND
i	RESTORATION OF SUM INSURED for Sum Insured between Rs.3lacs &10lacs, both slabs inclusive.	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured.	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	Not available
ii	PERSONAL ACCIDENT	CSI in multiples of Rs.1,00,000/- upto Rs.5,00,000/-per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.3lacs is allowed subject to this being lower than the CSI of the Insured	CSI in multiples of Rs.1,00,000/- upto Rs.10,00,000/-per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.5lacs is allowed subject to this being lower than the CSI of the Insured	CSI in multiples of Rs.1,00,000/- upto Rs.20,00,000/-per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.10lacs is allowed subject to this being lower than the CSI of the Insured
iii	LIFE HARDSHIP SURVIVAL BENEFIT	Plans as defined below	Plans as defined below	Plans as defined below

- i. Amount payable under this section is in addition to the Sum Insured under clause 1.2
- ii. Co-payment will not apply on Personal Accident and Life Hardship Survival Benefit covers.

2.1 RESTORATION OF SUM INSURED: If during the Policy Period the Sum Insured gets reduced or exhausted on account of a claim under the Policy, the Sum Insured is automatically restored to the extent of the claim amount but not exceeding the Restoration limit opted (50% / 100% of Sum Insured) at the inception of the Policy.

The above is subject to the following:

- i. Aggregate of all the restored amounts during the Policy Period shall not exceed 50% / 100% of the Sum Insured, as opted by the Insured.
- ii. At no point of time during the Policy Period, will the available coverage be more than the Sum Insured mentioned in the Schedule.
- iii. Aggregate of all the claims payable for any one Insured Person under the Policy shall not be more than the Sum Insured.

- iv. During a Policy Period, the maximum amount for any one claim payable shall be the Sum Insured and the aggregate of all claims payable shall not exceed the sum of the Sum Insured and Restored Sum Insured.

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

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

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

EXCLUSIONS: The Company shall not be liable under the Personal Accident section for injuries / death on account of

- i. Intentional self-Injury, suicide or attempted suicide
- ii. Whilst under the influence of intoxicating liquor or drugs
- iii. engagement in 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, waveski surfing, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and similar 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, unless specifically covered and endorsed on the Policy.
- iv. Directly or indirectly caused by venereal disease(s) or insanity
- v. Arising or resulting from insured committing breach of law with criminal intent
- vi. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainments of people
- vii. Directly or indirectly caused by or arising from ionizing radiations or contamination by radioactivity from any nuclear fuel, nuclear weapon material, or from any nuclear waste from the combustion of nuclear fuel.
- viii. Directly or indirectly caused by, contributed to, aggravated or prolonged by childbirth or from pregnancy or in consequence thereof.

2.3 LIFE HARDSHIP SURVIVAL BENEFIT PLAN: If during the Policy Period, any Insured Person is diagnosed with any of the 11 critical Illnesses defined hereunder and which results in admissibility of a claim under clause 1.2 A of the Policy, then a survival benefit as mentioned below, shall become payable to the Insured Person. However, this benefit shall not be available for the Illness which the Insured Person is already suffering from (irrespective of the stage of the disease) at the time of opting for this cover for the first time.

Plan	Total amount payable	Amount payable on survival for 180 days and above from the date of discharge from the Hospital (the first discharge date when more than one Hospitalisation is involved).	Amount payable on survival for 270 days and above from the date of discharge from the Hospital (the first discharge date when more than one Hospitalisation is involved).
A	15 % of Sum Insured under the Policy	5% of the Sum Insured	10% of the Sum Insured
B	25 % of Sum Insured under the Policy	10% of the Sum Insured	15% of the Sum Insured

- i. Limits under this section indicate the aggregate liability of the Company for one or more claims under the Policy in respect of one or all the Insured Persons covered under the Policy.
- ii. Further, for a particular disease, the above benefit shall be paid only once during the lifetime of the Insured Person.

CRITICAL ILLNESSES COVERED:

1. CANCER OF SPECIFIED SEVERITY: A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukaemia, lymphoma and sarcoma.

The following are excluded -

- i. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- ii. Any skin cancer other than invasive malignant melanoma
- iii. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
- iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- v. Chronic lymphocytic leukaemia less than RAI stage 3
- vi. Micro carcinoma of the bladder
- vii. All tumours in the presence of HIV infection.

2. FIRST HEART ATTACK - OF SPECIFIED SEVERITY

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- I. The first occurrence of myocardial infarction which means the death of a portion of the Heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria
- i. A history of typical clinical symptoms consistent with the diagnosis of Acute myocardial Infarction (for e.g typical chest pain)
 - ii. New characteristic electrocardiogram changes
 - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. The following are excluded:
- i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of troponin I or T
 - ii. Other acute Coronary Syndromes
 - iii. Any type of angina pectoris.

3. OPEN CHEST CABG

I. The actual undergoing of open chest Surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

- i. Angioplasty and/or any other intra-arterial procedures
- ii. Any keyhole or laser Surgery.

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of open heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based technique including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all the following:

- i. No response to external stimuli continuously for atleast 96 hours.
- ii. Life support measures are necessary to sustain life; and
- iii Permanent neurological deficit which must be assessed atleast 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS:

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical

clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

- i. Transient ischemic attack (TIA)
- ii. Traumatic Injury of Brain
- iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of

- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner

II. The following are excluded:

- i Other stem cell transplants
- ii Where only islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTENT SYMPTOMS

I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following

- i investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
- ii there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and
- iii well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

II. Other causes of neurological damage such as SIE and HIV are excluded.

3. DEFINITIONS:

- 3.1 ACCIDENT:** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 3.2 AMBULANCE SERVICES:** means ambulance service charges reasonably and necessarily incurred in shifting the Insured Person from residence to Hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the Hospitalisation expenses are admissible under the Policy.
- 3.3 ALTERNATIVE TREATMENTS:** are forms of treatments other than ‘Allopathy’, or ‘modern medicine’ and include Ayurveda, Unani, Siddha and Homeopathy in the Indian context.
- 3.4 ANY ONE ILLNESS:** means continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital /Nursing Home where treatment may have been taken..
- 3.5 CASHLESS FACILITY:** means a facility extended by the insurer to the insured where the payments of 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 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 upon.
- 3.8 CO-PAYMENT:** is a cost-sharing requirement under a health insurance Policy that provides that the Policy holder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.
- 3.9 CONTRIBUTION:** Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:
- a) is fixed in nature:
 - b) does not have any relation to the treatment costs;
- 3.10 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:** refers to medical treatment, and/or surgical procedure which is:
- a) undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hrs because of technological advancement, and
 - b) which would have otherwise required a Hospitalisation of more than 24 hours.

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

- 3.12 DENTAL TREATMENT:** is treatment carried out by Dental Practitioner, including examination, fillings (where appropriate), crowns, extractions and Surgery excluding any form of cosmetic Surgery/implants.

- 3.13 DOMICILIARY HOSPITALISATION BENEFIT** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- i the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- ii the patient takes treatment at home on account of non availability of a room in a Hospital.

- 3.14 FAMILY:** consists of the Insured and / or any one or more of the family members as mentioned below:

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

- 3.15 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.

- 3.16 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 In-patient beds, in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;
- c) has qualified Medical Practitioner (s) in charge round the clock;
- d) has a fully equipped operation theatre of its own where surgical procedures are carried out

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

3.17 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.

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

3.19 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.

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

3.21 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.

3.22 INTENSIVE CARE UNIT: means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

3.24 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.

3.25 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.

3.26 MEDICAL ADVICE: means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

3.27 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.

3.28 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 MEDICALLY NECESSARY TREATMENT: any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- i. is required for the medical management of the Illness or Injury suffered by the insured;
- ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a Medical Practitioner;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.30 NEW BORN BABY: means a baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

3.31 NETWORK PROVIDER: means Hospitals or healthcare providers enlisted by an insurer or by a TPA and insurer together, to provide medical services to an insured on payment, by a cashless facility.

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

3.33 NOTIFICATION OF CLAIM: is a process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address/telephone number, to which it should be notified.

3.34 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.

3.35 PRE-HOSPITALISATION EXPENSES: means medical expenses incurred during the period upto 30 days prior to the date of admission in the Hospital, provided that:

- i. Such Medical Expenses are incurred 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 POST-HOSPITALISATION EXPENSES:** means medical expenses incurred for a period upto 60 days from the date of discharge from the Hospital, provided that:
- i. Such Medical Expenses are incurred 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.
- 3.37 PRE EXISTING DISEASE:** means any condition, ailment or Injury or related condition(s) for which the Insured Person(s) had signs or symptoms, and / or was diagnosed, and / or received medical advice / treatment within 48 months prior to the first Policy issued by the insurer
- 3.38 POLICY PERIOD :** means the period of coverage as mentioned in the schedule
- 3.39 PORTABILITY:** means transfer by an individual health insurance Policy holder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.
- 3.40 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.
- 3.41 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 .
- 3.42 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 waiting periods.
- 3.43 ROOM RENT:** means the amount charged by a Hospital for the occupancy of a bed on per day (24hours) basis and shall include associated medical expenses.
- 3.44 SURGERY/ SURGICAL OPERATION:** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or 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 licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.
- 3.46 UNPROVEN/EXPERIMENTAL TREATMENT:** Treatment including drug experimental therapy which is not based on established medical practice in India.

4. GENERAL 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 Disease (whether treated / untreated, declared or not declared in the proposal form), which are excluded upto 48 months of the Policy being in force. Pre-existing diseases shall be covered only after the Policy has been continuously in force for 48 months.

For the purpose of applying this condition, the date of inception of the first indemnity based health Policy taken shall be considered, provided the renewals have been continuous and without any break in period, subject to portability condition.

This exclusion shall also apply to any complication(s) arising from pre existing diseases. Such complications will be considered as part of the Pre existing health condition or Disease.

4.2 Any disease other than those stated in clause 4.3, 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.	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.	2 Years
xviii	Diabetes.	2 Years
xix	Calculus diseases.	2 Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Congenital internal diseases.	2 Years

xxiii	Joint Replacement due to Degenerative condition.	4 Years
xxiv	Age related osteoarthritis and Osteoporosis.	4 Years

If the above diseases are pre-existing at the time of inception, Exclusion no.4.1 for pre-existing disease shall be applicable.

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

- 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 (except as covered under 1.2 B(ii)), inoculation or change of life 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, hearing aids etc.
- 4.7 Any dental treatment or Surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, crowns, root canal treatment including treatment for wear and tear etc., 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 and diseases / accident due to, and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc, any disease or Injury as a result of committing or attempting to commit a breach of Law with criminal intent.
- 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 or Nursing Home 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 etc., unless forming part of treatment for Injury or disease as certified by the attending physician.
- 4.12 Any treatment 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 (not applicable in Diamond Plan to the extent given under 1.5), except in the case of

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.

- 4.13 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine (other than Ayurveda, Siddha, Unani & Homeopathy as expressed in clause 1.2.A1) and related treatment including acupressure, acupuncture, magnetic and such other therapies.
- 4.14 Expenses for investigation/treatment irrelevant to the disease for which admitted or diagnosed. Private nursing charges, Referral fee to family doctors, out station consultants / Surgeons fees etc.
- 4.15 Genetic disorders and 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, Infusion pump etc., Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps, splints, slings, braces, Stockings etc. of any kind, Diabetic foot wear, Glucometer, Thermometer, Blood Pressure monitoring machine and similar related items and also any medical equipment which is subsequently used at home. Exhaustive list available on our website ([www. orientalinsurance.org.in](http://www.orientalinsurance.org.in)).
- 4.17 All non medical expenses including personal comfort and convenience items or services such as Wi-Fi/internet charges telephone, television, ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc, guest services and similar incidental expenses or services etc.
- 4.18 Change of treatment from one system of medicine to another unless agreed / allowed and recommended by the 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, and similar services or supplies.
- 4.21 Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar other activities, unless specifically agreed and endorsed on the Policy.
- 4.22 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 or similar establishments.
- 4.23 Any stay in the Hospital for any domestic reason or where no active regular treatment is given by the specialist.
- 4.24 Out patient Diagnostic, Medical or Surgical procedures or treatments, 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.
- 4.25 Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.

- 4.26 Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the Hospital.
- 4.27 Doctor's home visit charges, Attendant / Nursing charges during pre and post Hospitalisation period.
- 4.28 Pre and Post Hospitalisation expenses unrelated with disease / Injury for which Hospitalisation claim has been admitted under the Policy.
- 4.29 Compulsory Co-Payment: Under the SILVER plan the insured has to bear 10% of admissible claim amount in each and every claim.

5. CONDITIONS

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

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

5.3 PAYMENT OF PREMIUM: The premium under this Policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. The due payment of premium and the observance and 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 authorised official of the Company.

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

5.5 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.

- i. Original bills, all receipts and discharge certificate / card from the Hospital.
- ii. All documents pertaining to the Illness, starting from the date it was first detected, i.e Doctor's consultations reports / history
- iii. Medical history of the patient recorded by the Hospital.
- iv. Original Cash-memo from the Hospital (s) / chemist (s) supported by proper prescription.

- v. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending Medical Practitioner / Surgeon demanding such tests.
 - vi. Original attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bills / receipts etc.
 - vii. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
 - viii. MLC/FIR/Post Mortem Report,(if applicable)
 - ix. Disability certificate, Death certificate (if applicable)
 - x. Documents in respect of organ donation claim, shall be in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs
 - xi. Details of previous policies, if the details are already not with TPA.
 - xii. Any other information required by TPA / Company.
- All documents must be duly attested by the Insured Person/Claimant.
 - In case of Post Hospitalisation treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. In addition insured should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.
 - Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.
 - On receipt of the last document/clarification, the Company/TPA shall within a period of 30 days offer a settlement of the claim to the insured. If the Company/TPA, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of the last document / clarification.

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

- 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. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the Policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as an in-patient.
- 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. The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of the discharge from Hospital / Nursing Home for consideration of Company / TPA.
- iii. 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 given to the treating Hospital / insured.

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

5.7 MEDICAL RECORDS:

- i. 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 which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this Policy or the Company's liability there under.
- ii. The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this Policy or the Company's liability there under.
- iii. 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.

5.8 PAYMENT OF CLAIM: All medical treatment for the purpose of this insurance will have to be taken in India only (except where the Policy has been extended to SAARC countries) and all claims shall be payable in Indian currency only. For the purpose of claims settlement, currency conversion rate on the date of admission to Hospital would apply.

Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In case of any delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

5.9 CONTRIBUTION: If the Insured Person is covered under more than one Policy issued by the Company or by any other Insurer, where such policies indemnify treatment cost, the Insured Person shall have the right to require a settlement of his claim in terms of any of his policies, provided the admissible claim is within the limits of and according to the terms of the chosen Policy.

If the amount to be claimed exceeds the Sum Insured under a single Policy after considering Deductibles or Co-payments, the Insured Person shall have the right to choose Insurer by whom the claim is to be settled. In such cases the Company shall not be liable to pay or contribute more than its rateable proportion of the admissible claim.

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

5.10 CLAIM FALLING IN TWO POLICY PERIODS: If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period. Such eligible claim amount to be payable to the Insured, shall be reduced to the extent of premium to be received for the renewal/due date of premium of Health Insurance Policy, if not received earlier.

5.11 REPUDIATION:

- i. The Company, shall repudiate the claim if not payable under the Policy. The Company / TPA shall mention the reasons for repudiation in writing to the Insured Person. The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002.
- ii. If the insured is not satisfied with the reply of the Customer Service department under 5.11 (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.20 lacs.

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

5.13 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.

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.

5.14 FRAUD / MISREPRESENTATION / CONCEALMENT: Non – disclosure, concealment or misrepresentation of material facts or making false statements in the Proposal Form and/ or in the Claim Form or any other document, shall render the Policy null and void ab initio and the Company shall not be liable under this Policy. The Company shall, also not be liable under the Policy in respect of any claim, if such claim be in any manner- intentionally or fraudulently or otherwise misrepresented or concealed or involves making false statement or submitting false bills whether by the Insured Person or any other person/ Institution/ Organisation on his behalf. Company shall be at liberty to take suitable legal action against such Insured Person/ Institution/ Organisation as per the laws.

5.15 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 30 (Thirty) days notice by registered post at the Insured's last known address; and in such an event, the Company shall refund to the Insured a pro-rata premium for un-expired Policy Period only. However, no refund shall be made when cancellation is on grounds of fraud or moral hazard.

The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given below) provided no claim has occurred during the Policy Period up to date of cancellation.

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

OTHER TERMS & CONDITIONS

6.1 FAMILY SIZE: Minimum two persons (falling within the definition at 3.14) to be covered under the Policy.

Persons becoming ineligible on account of above provision for coverage under the existing Policy, may migrate to another suitable Policy at the expiry of this Policy. Upon such migration, the credits gained by the concerned Insured Person, for pre-existing conditions and time-bound exclusions shall be transferred to the migrated Policy, provided the Policy has been maintained without a break.

6.2 SUM INSURED: Policy has three Plans-Silver Plan-Sum Insured upto Rs.5lacs, Gold Plan upto Rs.10lacs, Diamond Plan upto Rs.20lacs.

Minimum Sum Insured for the persons taking this Policy for the first time is Rs.2lacs. However, those Insureds who were already covered for Rs.1lac Sum Insured under Happy Family Floater Policy, may continue with the earlier Sum Insured.

Also, those Insureds who were earlier covered for Rs.1.5lacs Sum Insured under Happy Family Floater Policy, have the option to take the Sum Insured of Rs.1lac, if for any reason, they do not want to shift to higher Sum Insured.

No new member is allowed to be included in Rs.1lac Sum Insured.

6.3 ENTRY AGE: Maximum Entry Age under the Policy is 65years for all members. However, with a compulsory co-payment of 20% of each and every claim, persons above the age of 65 and upto 70 years of age can also be covered under Silver or Gold Plan, but not under Diamond Plan. For such Insured Persons the co-payment will apply in all subsequent Renewals also.

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

- i. newly wed spouse within 90days of marriage or at the time of renewal of the Policy.
- ii. new born child from 91st day of birth or at the time of renewal of the Policy.

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

6.5 NO CLAIM DISCOUNT / LOADING: This is a one-time benefit for those Insured Persons covered under Happy Family Floater Policy. Happy Family Floater Policy had the provision of No Claim Discount / Loading, which has been discontinued under Happy Family Floater Policy-2015. However,

- i. The discount on account of 'No Claim' that would have been earned by the Insured on renewal of the Happy Family Floater Policy, would be allowed when the Policy is renewed for the first time, into Happy Family Floater Policy-2015. However, there will be no change in discount even if there are no claims reported under the subsequent Happy Family Floater Policy-2015 Policy(ies). This discount shall continue till a claim is reported under the Policy and upon reporting of a claim, any discount earned on account of 'No Claim' shall be forfeited. However, claim under PA section will not affect NCD earned thus far.
- ii. The insured persons with claim loading(s) on their previous policies will not have any loading on the premium on renewal into Happy Family Floater Policy -2015, i.e loadings on account of claims are discontinued.

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

- i. On renewal, Sum Insured can be increased to the immediate higher slab.
- ii. If, on renewal, the size of the family increases, Sum Insured can be increased to maximum two slabs higher.
- iii. If there are no claims reported in the two immediate preceding Policy Periods, change to the next Plan (Silver to Gold, Gold to Diamond) at the initial SI slab, or two steps higher from the current SI, whichever is more, is allowed.
- iv. Change of Plan is not allowed for a Policy covering any person above the age of 70years. However, Increase in Sum Insured within the same Plan is allowed as per above provisions.
- v. Notwithstanding above provisions, no increase in Sum Insured is allowed in policies where there are claims reported in two successive Policy Periods.

6.7 MIGRATION: Any person insured under our Individual/Group Health Policy may migrate into Happy Family Floater Policy-2015 at the time of renewal of his policy. Upon such migration, the credits gained by the concerned Insured Person, for pre-existing conditions and time-bound exclusions shall be maintained under Happy Family Floater Policy-2015, provided there is no break in the Policy.

7. 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

- i. 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 Insured, a deduction towards the proportionate risk premium for period on cover or
- iii. where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

Also, as a one time option, the Insureds who have, upon renewal, got the Happy Family Floater Policy -2015, for the first time, will also get the option of the Free look period as stated above.

8 . 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.

9. RENEWAL OF POLICY:

- i 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 including the grace period of 30 days) of premium **or** the proposal form **or** of the Medical Practitioner's report wherever required or due to any other reason whatsoever
- ii The Company may revise the premium rates and / or the terms & conditions of the Policy, upon renewal thereof, only after due approval from IRDAI. Renewal of this Policy is not automatic; premium due must be paid to the Company before the due date. Any revision or modification in the Policy will be notified to the policyholders three months in advance.
- iii 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.
- iv If the Policy is renewed for enhanced Sum Insured then the clauses (4.1, 4.2 & 4.3) as applicable to a fresh 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 four continuous renewals 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.

10. 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.

Portability shall be allowed in the following cases:

- i. All individual health insurance policies, including family floater policies, issued by non-life insurers.
- ii. Individual members, including the family members covered under any group health insurance Policy of a non-life insurance Company shall have the right to migrate from such a group Policy to an individual health insurance Policy or a family floater Policy with the same insurer. One year thereafter, the Insured Person shall be accorded the right to port to another non-life insurance Company.

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

12. 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).

- 13. 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.
- 14. 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.
- 15. (a) DISCOUNT ON OMP PREMIUM:** A discount of 15% on the premium of Overseas Mediclaim Policy would be allowed when an Insured Person covered under this Policy, takes the Overseas Mediclaim Policy from the Company, provided this Policy is valid as on the date of taking the Overseas Mediclaim Policy of the Company.
- (b) DISCOUNT ON DIRECT ON-LINE POLICIES:** A discount of 5% on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.
- 16. IRDAI REGULATION:** This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2002 and IRDAI (Health Insurance) Regulations 2013 and Guidelines on Standardisation in health insurance, as amended from time to time.
- 17. DISCLOSURE TO INFORMATION NORM:** The Policy shall be void, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
- 18. 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.

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 epicanthus
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 (hysterotomy)
76	Therapeutic curettage
77	Culdotomy
78	Incision of the vagina
79	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
80	Incision of the vulva
81	Operations on Bartholin's glands (cyst)
N	Operations on the prostate & seminal vesicles
82	Incision of the prostate
83	Transurethral excision and destruction of prostate tissue
84	Transurethral and percutaneous destruction of prostate tissue
85	Open surgical excision and destruction of prostate tissue
86	Radical 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