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

PROSPECTUS

HEALTH OF PRIVILEGED ELDERS

(SENIOR CITIZEN SPECIFIED DISEASES INSURANCE)

SALIENT FEATURES OF THE POLICY:

- Exclusively designed for Citizens aged 60 years and above
- Policy is available for Sum Insured 1 lac, 2 lac, 3 lac, 4 lac and 5 lacs.
- Covers specified diseases only.
- Compulsory co-payment of 20% on admissible claim amount.
- Discount in premium for opting Voluntary Co-payment.
- No claim discount in premium.
- Loading for new entrants.
- Benefit of continuity extended if already insured with any mediclaim policy of the Company.
- TPA service available.
- Cashless Service through TPA only and limited to Rs. 1 lakh.
- Telemedicine expenses.
- Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines if, treatment is taken in any AYUSH Hospital.

This policy is available to any Indian citizen who is aged 60 years and above and for hospitalization in India only.

The proposer has to submit any of the following documents as age proof:

(a) Birth Certificate
(b) Matriculation Certificate
(c) School Leaving Certificate
(d) Photo Voter Identity Card
(e) Driving License
(f) PAN Card
(g) Passport

The Policy reimburses the payment of hospitalization and / or domiciliary hospitalization expenses for the specified diseases contracted or injury sustained by the insured persons. The settlement of the claim will be done by the Company/TPA either to the network hospital or to the insured.

Only the following Specified Diseases / illness/ injury are covered under the policy and the maximum liability of the Company in respect thereof shall be as follows:

Sr. No.	Name of Disease	Maximum Limit of Liability per illness (including domiciliary hospitalization benefit, if any)
1.	**Accidental Injury**	100% of Sum Insured
2.	**Knee Replacement**	70% of Sum Insured
3.	**Cardio Vascular Diseases**	50% of Sum Insured
4.	**Chronic Renal Failure**	50% of Sum Insured
5.	**Cancer**	50% of Sum Insured
6.	**Hepato-Billiary Disorders**	50% of Sum Insured
7.	**Chronic Obstructive Lung Diseases**	20% of Sum Insured
8.	**Stroke**	20% of Sum Insured
9.	**Benign Prostrate**	15% of Sum Insured

10.	**Orthopedic Diseases**	15% of Sum Insured
11.	**Ophthalmic Diseases**	10% of Sum Insured

Note: Company's Liability in respect of all claims admitted during the Period of insurance shall not exceed the Sum Insured per Person mentioned in the Policy / Schedule.

REASONABLE & NECESSARY EXPENSES UPTO THE FOLLOWING LIMITS ARE PAYABLE / REIMBURSABLE UNDER THE POLICY, FOR THE SPECIFIED DISEASES / ILLNESS/ INJURY ONLY, WITHIN THE OVERALL LIMIT AS SPECIFED ABOVE:

a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1% of the Sum Insured per day.

b. I.C. Unit expenses not exceeding 2% of the Sum Insured per day.
(Stay in the Room and the stay in I.C.U., if required, should not exceed total number of days of admission in the hospital).

c. Ambulance Services Charges per illness by registered ambulance – Actual Expenses or Rs 1000/- whichever is less shall be reimbursable in case patient has to be shifted from residence to hospital in case of admission in Emergency Ward / I.C.U. Or from one Hospital / Nursing home to another Hospital / Nursing Home for hospitalization.

d. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.

e. Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc.

Note: Only reasonable and necessary expenses based on the severity **(minor / medium / major)** of the Specified Diseases / illness/ injury will be payable under the policy but not exceeding the maximum limit irrespective of the expenses incurred by the insured.

f. 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. Such reasonable incurred expenses will be reimbursable wherever consultation with a Registered medical practitioner is allowed in the terms and conditions of policy contract and shall be subject to Limits/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.

g. DOMICILIARY HOSPITALISATION BENEFIT: Domiciliary hospitalization means medical treatment for a period exceeding three days for such 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:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non-availability of room in a hospital. Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover

a) Expenses incurred for pre and post hospital treatment and
b) Expenses incurred for treatment for any of the following diseases :
i. Chronic Nephritis and Nephritic Syndrome,
ii. Pyrexia of unknown origin for less than 10 days,
iii. Upper Respiratory Tract infection including Laryngitis and Pharingitis,
iv. Arthritis, Gout and Rheumatism.

Note: **DOMICILIARY HOSPITALISATION BENEFIT** shall not exceed Rs. 20,000/- (Twenty Thousand rupees) per insured in respect of all claims admitted during the policy period.

h. 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
Oral chemotherapy	Per policy period 25% of SI, subject to maximum INR 50,000.
Immunotherapy- Monoclonal Antibody to be given as injection	Per policy period 10% of SI, subject to maximum INR 50,000.
Intra vitreal injections	Per policy period 10% of SI, subject to maximum INR 50,000.
Robotic surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.
Stereotactic radio surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.
Vaporization of the prostrate (Green laser treatment or holmium laser treatment)	Per policy period 10% of SI, subject to maximum INR 50,000.
IONM - (Intra Operative Neuro Monitoring)	Per policy period 10% of SI, subject to maximum INR 50,000.

2 DEFINITIONS:

‘‘**HOSPITAL/NURSING HOME:** means any institution established for in- patient care and day care treatment of Illness and / or injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act*OR complies with all minimum criteria asunder:

a) has qualified nursing staff under its employment round the clock;

b) has at least 10 In-patient beds, in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;

c) has qualified Medical Practitioner (s) in charge round the clock;

d) has a fully equipped operation theatre of its own where surgical procedures are carried out

e) Maintains daily records of patients and makes these accessible to the Insurance Company’s authorized personnel.

*Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

1. The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002
2. The Bombay Nursing Homes Registration Act, 1949
3. The Delhi Nursing Home Registration Act, 1953
4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (Ragistrikaran Tatha Anugyapan) Adhiniyam, 1973.
5. The Manipur Homes and Clinics Registration Act, 1992
6. The Nagaland Health Care Establishments Act, 1997
7. The Orissa Clinical Establishments (Control and Regulations) Act, 1990
8. The Punjab State Nursing Home Registration Act, 1991
9. The West Bengal Clinical Establishment Act, 1950

AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council ofIndian Medicine/ Central Council for Homeopathy; or

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

i. Having at least five in- patient beds;

ii. Having qualified AYUSH Medical Practioner in charge round the clock;

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

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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.

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

HOSPITALISATION PERIOD: Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 (Twenty Four) hours. However,

(A) This time limit shall not apply to following specific treatments taken in the Networked Hospital / Nursing Home where the Insured is discharged on the same day. Such treatment shall be considered to be taken under Hospitalisation Benefit.

i. Haemo Dialysis,
ii. Parentral Chemotherapy,
iii. Radiotherapy,
iv. Eye Surgery,
v. Lithotripsy (kidney stone removal),
vi. Dental surgery following an accident
vii. Coronary Angioplasty
viii. Coronary Angiography
ix. Surgery of Gall bladder, Pancreas and bile duct
x. Surgery of Prostrate.
xi. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
xii. Arthroscopic Knee surgery.
xiii. Laproscopic therapeutic surgeries.
xiv. Surgery under General Anaesthesia.
xv. Or any such procedure agreed by TPA/Company before treatment.

(B) Further if the treatment / procedure / surgeries of above diseases are carried out in Day Care Centre, which 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 min- imum criteria as under:-

1. has qualified nursing staff under its employment,
2. has qualified medical practitioner (s) in charge,
3. has a fully equipped operation theatre of its own, where surgical proceduresare carried out-
4. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel, the requirement of minimum number of beds is overlooked.

(C). This condition of minimum 24 (Twenty Four) hours Hospitalisation shall also not apply provided:

i medical treatment, and/or surgical procedure is:
ii undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
iii which would have otherwise required a hospitalization of more than 24 hours.

ABOVE ARE ADMISSIBLE SUBJECT TO TERMS & CONDITIONS OF THE POLICY.

NOTE: PROCEDURES / TREATMENTS USUALLY 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 (Twenty Four) HOURS.

AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical 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) in charge.
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

- the condition o f the patient is such that he/she is not in a condition to beremoved to a hospital, or
- the patient takes treatment at home on account o f non availability o f room ina hospital.

Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover

a) Expenses incurred for treatment for any of the following diseases :
   i. Chronic Nephritis and Nephritic Syndrome,
   ii. Pyrexia of unknown origin for less than 10 days,
   iii. Upper Respiratory Tract infection including Laryngitis and Pharingitis,
   iv. Arthritis, Gout and Rheumatism.

Note: DOMICILIARY HOSPITALISATION BENEFIT shall not exceed Rs. 20,000/- (Twenty Thousand rupees) per insured in respect of all claims admitted during the policy period.

3 ADDITIONAL DEFINITIONS :

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

SENIOR CITIZEN: Means an Indian citizen who has attained the age of 60 (sixty) years as on the date of proposal.

INSURED PERSON: Means Person(s) named on the schedule of the policy.

SPECIFIED DISEASES: The diseases as mentioned in para 1 above.

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

THIRD PARTY ADMINISTRATOR (TPA): means any Company who has obtained license from IRDA to practice as a third party administrator and is appointed by the Company.

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.

HOSPITALISATION PERIOD: The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 hours except for specified procedures/ treatment where such admission could be for a period of less than 24 consecutive hours.

PRE- HOSPITALISATION EXPENSES: Medical Expenses incurred during the period upto 30 days prior to the date of admission, 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.

POST- HOSPITALISATION EXPENSES: Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, providedthat:

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.

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

QUALIFIED NURSE: Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council o f any state in India.

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

a) that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

b) for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

IN-PATIENT: An Insured person who is admitted to hospital and stays for at least 24 (Twenty Four) hours for the sole purpose of receiving the treatment for covered ailment / illness / disease / injury / accident during the currency of thepolicy.

CASHLESS FACILITY: : It 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**.**

CO-PAYMENT: A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment doesnot reduce the sum insured.

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

LIMIT OF INDEMNITY: means the amount stated in the schedule against the name of each insured person which represents maximum liability for any and all claims made during the policy period in respect of that insured person in respect of hospitalization taking place during currency of the policy.

ANY ONE ILLNESS: Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge, whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.

PERIOD OF POLICY: This insurance policy is issued for a period of one year as shown in the schedule.

REASONABLE AND CUSTOMARY CHARGES: 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 . For a networked hospital means the rate pre-agreed between Network Hospital and the TPA / Company, for surgical / medical treatment that is necessary for treating the insured person who was hospitalized.

COMPULSORY CO-PAYMENT: Insured has to bear 20% (Twenty percent) of admissible claim amount in each and every claim.

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

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.

VOLUNTARY CO-PAYMENT:: The insured may opt to bear a part of the claim amount (after application of compulsory co-payment) for which following discounts are applicable, subject to a maximum of 50% (Fifty percent)

Co-payment Opted	Discount available on premium
10%	**10%**
20%	**20%**
30%	**30%**
40%	**40%**
50% & above	**50%**

NO CLAIM DISCOUNT: The insured shall be entitled for No Claim Discount at the rate of 5% of the renewal premium payable after every claim free policy year, subject to a maximum of 20%, as per table below, provided the policy is renewed without any break:

Discount available on renewal premium payable after one (or the first) claim free annual policy	5%
Discount available on renewal premium payable on second continuous claim free renewal of annual Policy	10%
Discount available on renewal premium payable on third continuous claim free renewal of annual Policy	15%
Discount available on renewal premium payable on fourth continuous claim free renewal of annual Policy	20%

No Claim Discount shall become 'nil' once a claim is paid or becomes payable under the policy, irrespective of the amount of claim.
For No Claim Discount, renewal of this particular policy shall only be considered and no benefit of any other insurance policy shall be allowed.

At the discretion of the Company where policy is renewed within 7 (seven) days from the expiry date, the renewal is permissible with the applicable No Claim Discount.

GRACE PERIOD: It 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 no premium is received.

4 EXCLUSIONS:

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

Any disease / health condition / illness / ailment or any condition arising there from other than those specified in the policy as covered.

Pre-existing Diseases - code -ExcI0 1

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with the insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of the prior coverage.
d) Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

Specified disease / procedure waiting period- 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 for first two policy years.

i Non infective Arthritis.
ii Cataract.
iii Surgery of benign prostatic hypertrophy.
iv Surgery of gallbladder and bile duct excludingmalignancy.
v Surgery of genitor urinary system excluding malignancy.
vi Gout and Rheumatism.
vii Calculus diseases.
viii Joint Replacement due to Degenerative condition.
ix Age related osteoarthritis and Osteoporosis.

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 are covered.

b). This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
c). The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

If the continuity of the renewal is not maintained then subsequent cover shall be treated as fresh policy and clauses 4.2, 4.3, 4.4 shall apply afresh unless agreed by the Company and suitable endorsement is passed on the policy.

Investigation & Evaluation – Code – ExcI04

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:

b) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such a bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

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

Change of Gender Treatments : Code – 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 practitioner.

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 –ExcI10

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

Excluded Providers- Code – ExcI11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policy holders are not admissible. However, in case of life threatening situations **or** following an accident, expenses upto the stage of stabilization are payable but not complete claim.

Treatment for, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – Code- ExcI12

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- ExcI13

Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.- Code- ExcI14

Refractive Error- Code- ExcI15

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

Unproven Treatments- Code – ExcI16

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.

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

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

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

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

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

Any expenses incurred on OPD treatment

Treatment taken outside the geographical limits of India.

5. 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, mentioned therein, will be permanently excluded from the policy coverage:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified 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 or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.

7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.- Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (co-infection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (co-infection) 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

6 CONDITIONS

ENTIRE CONTRACT: the policy, proposal form, prospectus and declaration given by the insured shall constitute the complete contract of insurance. Only 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.

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.

PAYMENT OF PREMIUM: The premium payable 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 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 authorized official of the Company.

The policy shall be deemed to be void ab-initio (since its inception) if the payment instrument is dishonored for any reasons whatsoever and under this circumstance the Company shall not admit any liability whatsoever under this policy.

FREE LOOK PERIOD:

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

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

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

i A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or

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

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

NOTICE 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 / 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 notice should be given within 48 hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier, unless waived in writing by the Company.

CLAIM DOCUMENTS: Final claim along with hospital receipted original Bills/Cash memos/reports, claim form and list of documents as listed below should be submitted to the Company / TPA within 7 (seven) days of discharge from the Hospital / Nursing Home.

a. Original bills, receipts and discharge certificate / card from the hospital.
b. Medical history of the patient recorded by the Hospital.
c. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
d. 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.

e. Attending Consultants / Anesthetists / Specialist certificates regarding diagnosis and bill / receipts etc.
f. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
g. Any other information required by TPA / Insurance Company.

All documents must be duly attested by the insured person.

In case of post hospitalization treatment [limited to 60 (sixty) days] all supporting claim papers / documents as listed above should also be submitted within 7 (seven) days after completion of such treatment [up to 60 (sixty) 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.

NOTE: 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 on behalf of the insured to give such notice or file claim within the prescribed time limit. Otherwise Company / TPA has a right to reject the claim.

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

1) Claim in respect of Cashless Access Services shall be through the Company/TPA provided admission is in a listed hospital in the agreed list of the networked Hospitals / Nursing Homes 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 shall issue a pre- authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.
2) 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 claim and / or deficiency of service. 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 for reimbursement within 7 (seven) days of the discharge from Hospital / Nursing Home.
3) In case any information available to the TPA / Company which makes the claim inadmissible or doubtful requiring investigations, the authorization of cashless facility shall be withdrawn. However this shall be done by the Company/TPA before the patient is discharged from the Hospital.

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 rateable proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred. However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics.

B. ASSOCIATED MEDICAL EXPENSES:

· Doctor's fees / Consultant fees/RMO fees
· Nursing expenses including administration charges/ transfusion charges/ injection charges
· Surgeon fees / Asst Surgeon fees
· Anesthesia fees
· **Procedure charges of any kind which includes:-**

I) Chemotherapy/Radiotherapy charges
II) Nebulisation
III) Hemodialysis

IV) PICC line insertion
V) Catheterization charges
VI)Tracheotomy etc.
VII) IV charges
VIII) Blood transfusion charges
IX) Dialysis
X) Surgery Charges
· OT charges including OT gas, equipment charges

NON ADMISSION OF CLAIM:

A. The Insurer, shall repudiate the claim if not covered / not payable under the policy. The Insurer shall mention the reasons for in writing to the insured person. The insured person shall have the right to appeal / approach the Grievance Redressal Cell of the company at its policy issuing office, concerned Divisional Office, concerned Regional Office or the Grievance Cell of the Head Office of the Company, situated at A-25/27, Asaf Ali Road, New Delhi-110002, against the repudiation.

B. If the insured is not satisfied with the decision of the Grievance Cell (details as per clause no. 22) he / she may approach the Ombudsman of Insurance, established by the Central Government for redressal of grievances. The Ombudsman of Insurance is empowered to adjudicate on personal lines of insurance claims up to Rs.30 lacs (details of Ombudsman as per Annexure B).

C. Any medical practitioner authorized by the TPA/Company shall be allowed to examine theInsured Person with / without prior notice in case of any alleged injury or Disease requiring Hospitalization when and so often as the same may reasonably be required on behalf of theTPA/Company.

DISCLOSURE TO INFORMATION NORM

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

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

CONDITION PRECEDENT TO ADMISSION OF LIABILITY: The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

CANCELLATION CLAUSE:

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

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

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 (Thirty) 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.

DISCLAIMER OF CLAIM: It is also hereby further expressly agreed and declared that if the TPA/Company shall disclaim liability in writing to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have 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.

PAYMENT OF CLAIM: The policy covers illness, disease or accidental bodily injury sustained by the insured person during the policy period anywhere in India and all medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency without any interest thereof.

COST OF HEALTH CHECK : The Insured shall be entitled for reimbursement of cost of Health checkup undertaken once at the expiry of a block of every four continuous claim free underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average sum Insured during the block of four claim free underwriting years.

IMPORTANT

Both Health Check-up and No Claim Discount provisions are applicable only in respect of continuous insurance without break.

PERIOD OF POLICY: This insurance policy is issued for a period of one year.

PREMIUM REVISION CLAUSE: The above rates are valid for a period of 1 year only. The company may revise the premium rates and / or the terms & conditions of the policy upon renewal thereof as per IRDA guidelines prevailing at that time.

MIGRATION: The insured person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insuarnace product/plan offered by the Company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, atleast 45 days before, but not earlier than 60 days from the policy rnewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any healt insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

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

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

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

iv. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

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

7 PRE-ACCEPTANCE HEALTH CHECKUP: Any person desiring to take fresh insurance cover has to submit following medical reports (and any other medical reports) required by the company from authorized Network Diagnostic Centre.

This provision shall also be applicable for renewal where there is a break inpolicy period.

The cost of such check up shall be borne by the insured. However in case of fresh proposals, the Company shall reimburse per person 50% cost of Medical Check up.

MEDICAL TEST	PHYSICAL EXAMINATION
	URINE(MICROALBUMIN UREA)
	GLYCOCYLATED HAEMOGLOBIN
	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)
	X-RAY BOTH KNEES (ANTEPOSTERIOR AND LATREL)
	COMPLETE EYE TEST INCLUDING FUNDUS ETC
	STRESS TEST (TMT)

8 SUM INSURED: The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured opted by the Insured person. Minimum sum insured that can be selected is Rs 100,000/- and higher sum insured can be selected in multiples of Rs 100,000/- upto a maximum sum insured of Rs. 5,00,000/-.

9 AUTHORITY TO OBTAIN RECORDS:

a) The insured person agrees to and authorizes the disclosure to the insurer or the TPA or any other person nominated by the insurer 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 either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability there under.

b) The insurer and the TPA agree that they shall preserve the confidentiality of any documentation and

information that comes into their possession pursuant to (a) above and shall only use it in connection with any claim made under this policy or the insurer's liability there under

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

11 QUALITY OF TREATMENT : The insured acknowledges and agrees that payment of any claim by the insurer shall not constitute on part of the insurance 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 policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

12 ID CARD: The card issued to the insured person by the TPA to avail cash less 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 policy holders expense and the policy holder undertakes to indemnify the insurer /TPA for any liability whatsoever due to any misuse of the ID card by any person whomsoever.

14 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.

15 MORATORIUM PERIOD

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

16 Complete Discharge

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

POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES:

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

GRIEVANCE REDRESSAL:

In case of any grievance the insured person may contact the company through

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

Customer Service Department
4th Floor, Agarwal House
Asaf Ali Road,
New Delhi-110002.

For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac-c613-ffc05d578a3e

Insurance Ombudsman –If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-III & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html

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

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

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

SCHEDULE OF PREMIUM:

Premium Chart					
Sum Insured(INR)	100000	200000	300000	400000	500000
Age Group	Premium (INR)				
61-65	4725	9135	13020	16905	20685
66-70	5040	9555	13755	17745	21735
71-75	5985	11970	17115	22575	27405
76-80	6405	12600	17955	23835	28980
Above 80	6720	13230	19005	24990	30450

This Prospectus shall form part of your proposal form. Signatures hereunder confirm that you have noted the contents of the prospectus.

Name: Signature
Address:
Place: Date:

Note: For legal interpretation only English version will be valid.

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.

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 the Insurer.

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